STATE OF IOWA DEPARTMENT OF

Health AND Human SERVICES

Calendar Year 2022 External Quality Review Technical Report

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care plans' (MCPs') performance related to the quality, timeliness, and accessibility of care and services they provide, as mandated by Title 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Iowa Department of Health and Human Services[1-1] (HHS) has contracted with Health Services Advisory Group, Inc. (HSAG), as its external quality review organization (EQRO) to perform the assessment and produce this annual report.

Iowa Medicaid is the division of HHS that administers and oversees the Iowa Managed Care Program, which contracts with two managed care organizations (MCOs) to provide physical health, behavioral health, and long-term services and supports (LTSS) to Medicaid members. The Iowa 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]). HHS also contracts with two prepaid ambulatory health plans (PAHPs) to provide dental benefits for Medicaid (Dental Wellness Plan [DWP] Adults and DWP Kids) and Hawki members. The MCOs and PAHPs contracted with HHS during calendar year (CY) 2022 are displayed in Table 1-1.

Table 1-1—MCPs* in Iowa

MCO Name	MCO Short Name
Amerigroup Iowa, Inc. (Amerigroup)	AGP
Iowa Total Care, Inc. (Iowa Total Care)	ITC
PAHP Name	**PAHP Short Name**
Delta Dental of Iowa (Delta Dental)	DDIA
Managed Care of North America Dental (MCNA Dental)	MCNA

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

Scope of External Quality Review Activities

To conduct this annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for

[1-1] Effective July 1, 2022, the Iowa Department of Human Services and the Iowa Department of Public Health were merged into a single Iowa Department of Health and Human Services.

Medicare & Medicaid Services (CMS).[1-2] The purpose of these activities, in general, is to improve states' ability to oversee and manage MCPs they contract with for services, and help MCPs improve their performance with respect to quality, timeliness, and accessibility of care and services. Effective 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 2022 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, timeliness, and accessibility of care and services provided by each MCP. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

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

* 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.

** CMS has not yet issued the associated EQR protocol.

[1-2] 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: Jan 13, 2023.

[1-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Iowa Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR findings from the CY 2022 activities to comprehensively assess the MCPs' performance in providing quality, timely, and accessible healthcare services to Medicaid and Hawki members. For each MCP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MCP's performance, which can be found in Section 3 and Section 4 of this report. The overall findings and conclusions for all MCPs were also compared and analyzed to develop overarching conclusions and recommendations for the Iowa Managed Care Program. Table 1-3 highlights substantive conclusions and actionable state-specific recommendations, when applicable, for HHS, to drive progress toward achieving the goals of Iowa's Medicaid Managed Care Quality Assurance System (Quality Strategy) and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members.

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

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Behavioral Health	**Conclusions:** The Iowa Managed Care Program demonstrated strong performance as indicated by the results of the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-4] activity for the *Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence*; *Follow-Up After ED Visit for Mental Illness*; *Follow-Up After Hospitalization for Mental Illness*; and *Initiation and Engagement of AOD Abuse or Dependence Treatment* performance measures. All rates except those for *Follow-Up After Hospitalization for Mental Illness*, which ranked at or above the 75th percentile but below the 90th percentile, ranked at or above the 90th percentile. Also, rates for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* performance measures ranked at or above the 50th percentile but below the 75th percentile. The NAV activity further confirmed that the MCOs overall had a sufficient network of outpatient and inpatient behavioral health providers to deliver services to Iowa's managed care members. However, the remaining two performance measures under the Behavioral Health domain of the HEDIS activity have continued opportunities for improvement. The rate for *Diabetes Monitoring for People With Diabetes and Schizophrenia* ranked at or above the 25th percentile but below the 50th percentile, and the rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics* ranked below the 25th percentile.	☒ Quality ☒ Timeliness ☒ Access

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

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Recommendations: Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS consider revising its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. Additionally, while HHS requires the MCOs to conduct two mandated PIPs, HHS could add a provision to the contract requiring the MCOs to engage in two additional PIPs per year (e.g., two HSAG-validated PIPs and two non-HSAG-validated PIPs). HHS could specify the topics or areas the PIPs must address. One of these topics could be related to behavioral health. Further, HHS could consider setting minimum performance standards (MPSs) or performance thresholds for a select number of HEDIS performance measures which align with HHS' Quality Strategy goals. While these performance thresholds may or may not be tied to a payment incentive, setting a statewide performance threshold will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress in meeting HHS' established Quality Strategy goals and objectives.	
Access to Care	**Conclusions:** The results of the HEDIS activity demonstrated mixed results programwide related to primary and specialty care (excluding behavioral health and prenatal and postpartum care which are addressed under a different HHS Quality Strategy goal): • *Access to Preventive Care* domain—One performance measure rate ranked at or above the 75th percentile but below the 90th percentile, two rates ranked at or above the 50th percentile but below the 75th percentile, three rates ranked at or above the 25th percentile but below the 50th percentile, and one rate ranked below the 25th percentile. • *Women's Health* domain—Two performance measure rates ranked at or above the 50th percentile but below the 75th percentile, two rates ranked at or above the 25th percentile but below the 50th percentile, and two rates ranked below the 25th percentile. • *Living With Illness* domain—One performance measure rate ranked at or above the 90th percentile, two rates ranked at or above the 75th percentile but below the 90th percentile, three	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	rates ranked at or above the 50th percentile but below the 75th percentile, and two rates ranked below the 25th percentile. • *Keeping Kids Healthy* domain—One performance measure rate ranked at or above the 75th percentile but below the 90th percentile, five rates ranked at or above the 50th percentile but below the 75th percentile, one rate ranked at or above the 25th percentile but below the 50th percentile, and one rate ranked below the 25th percentile. • *Medication Management* domain—Two performance measure rates ranked at or above the 75th percentile but below the 90th percentile, seven rates ranked at or above the 50th percentile but below the 75th percentile, eight rates ranked at or above the 25th percentile but below the 50th percentile, and one rate ranked below the 25th percentile. Programwide, the highest-ranking performance measure was *Comprehensive Diabetes Care—HbA1c Testing,* while the lowest-ranking performance measures included *Use of Imaging Studies for Low Back Pain*, *Chlamydia Screening in Women*, *Statin Therapy for Patients With Cardiovascular Disease*, *Statin Therapy for Patients With Diabetes*, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*, and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*. Additionally, while no national comparisons or MPSs are available, the dental services performance measure rates were generally low: *Members Who Accessed Dental Care*—17.29 percent to 29.09 percent; *Members Who Received Preventive Dental Care*—35.86 percent to 71.93 percent; and *Members Who Received a Preventive Examination and a Follow-Up Examination Percentage*—39.62 percent to 59.69 percent. Further, through the NAV activity, the MCPs generally had sufficient provider networks, suggesting that members were experiencing other barriers to accessing primary, specialty, and dental care and services. **Recommendations:** Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS consider revising its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	While HHS requires the MCOs to conduct two mandated PIPs, HHS could also add a provision to the contract requiring the MCOs to engage in two additional PIPs per year (e.g., two HSAG-validated PIPs and two non-HSAG validated PIPs). HHS could specify the topics or areas the PIPs must address. Options for these topics could include prevention and care of acute and chronic conditions, high-risk services, oral health, etc. Additionally, through the NAV activity for the MCPs, provider-to member ratios were calculated. However, HHS does not have established MPSs. As such, HHS could update its network adequacy standards to include minimum required provider-to-member ratios for primary care providers (PCPs), specialists, and dentists. Further, as a new MCO is scheduled to join the Iowa Managed Care Program effective July 1, 2023, and membership will be reassigned across three MCOs, HHS could consider a disruption analysis in future NAV activities. A disruption analysis may provide HHS with valuable information on whether members retained access to their PCPs, and whether provider networks and time/distance access standards were impacted. Lastly, HHS could consider setting MPSs or performance thresholds for a select number of HEDIS performance measures which align with HHS' Quality Strategy goals. While these performance thresholds may or may not be tied to a payment incentive, setting a statewide performance threshold will assist HHS in quantitatively evaluating the Iowa Medicaid Managed Care Program's progress in meeting HHS' established Quality Strategy goals and objectives.	
Improving Coordinated Care	**Conclusions:** HHS required the MCOs to conduct a PIP related to *Timeliness of Postpartum Care*. Both MCOs received an overall validation status of *Met*, indicating the MCOs conducted appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement. Additionally, both MCOs demonstrated successes. Amerigroup's performance indicator achieved a rate of 76.9 percent, demonstrating a statistically significant improvement from the baseline rate which was 68.9 percent. Iowa Total Care also demonstrated programmatically significant improvement over the baseline performance through the implementation of provider education and member outreach which increased the number of pregnancy notifications received by the MCO from 2020 to 2021. Further, the programwide rate for the *Timeliness of Postpartum Care* indicator under the *Prenatal and Postpartum Care* performance measure ranked at or above the 50th percentile but below the 75th percentile, indicating many women had a postpartum visit on or between seven and 84 days after delivery of their baby. However, while not identified as an individual goal under HHS' MCO Quality Strategy goal, *Improving*	☒ Quality ☒ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Coordinated Care, the related *Timeliness of Prenatal Care* rate under the *Prenatal and Postpartum Care* performance measure ranked below the 25th percentile, indicating that many pregnant women receiving services under the Iowa Managed Care Program did not receive a timely prenatal care visit within the first trimester. Prenatal care is critical in ensuring healthy outcomes for new mothers and their babies, including a healthy birth weight. **Recommendations:** Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS consider revising its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. While the Iowa Managed Care Program is performing poorly when compared to national percentiles related to timely prenatal care, both MCOs demonstrated an improvement in performance from MY 2020 to MY 2021 (for Amerigroup, the rate increased 3.41 percentage points and for Iowa Total Care, the rate increased by 5.84 percentage points). Additionally, while there are continued opportunities to increase the number of pregnant women receiving timely prenatal care, the percentage of low birth weights for the Iowa Medicaid and CHIP population is 7.7 percent, which is below the national median rate of 9.7 percent (a lower rate indicates better performance).[1-5] As such, HHS should closely monitor year-over-year and long-term trending for the *Timeliness of Prenatal Care* rate and low birth weight for the Iowa Medicaid population for continued improvement. HHS should implement statewide improvement initiatives for any noted decrease in performance (i.e., decrease is the *Timeliness of Prenatal Care* rate, increase in low birth weight rates, and the correlation between the two measures). HHS could consider a statewide collaborative to identify the impact that untimely prenatal care has on member outcomes such as live births, low birth weight and pre-term births, and the financial impact to the Iowa Medicaid Managed Care Program due to poor outcomes.	

[1-5] Centers for Medicare & Medicaid Services. Live Births Weighing Less Than 2,500 Grams. Available at: https://www.medicaid.gov/state-overviews/scorecard/live-births-weighing-less-than-2500-grams/index.html. Accessed on: Feb 1, 2023.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Continuity of Care	**Conclusions:** HHS' contract with the MCPs requires the MCPs to implement mechanisms to ensure the continuity of care for members transitioning in and out of the MCPs' enrollment. These mechanisms include, but are not limited to, ensuring members have access to services consistently through the transition process; referring members to appropriate in-network providers; ensuring that MCPs fully comply with requests for historical utilization data in a timely manner; and ensuring new providers are able to obtain copies of a member's medical or dental record. Possible transitions include initial program implementation, initial enrollment with an MCP, transitions between MCPs during the initial 90 days of a member's enrollment, and at any time for cause. Additionally, through the PMV activity, HHS focused on a set of state-specific performance measures related to members receiving home and community-based services (HCBS) and the provision of person-centered care planning. Through the person-centered care planning process, the MCOs should also be addressing transitions of care between care settings. One of the measures validated through the PMV activity is *Member Choice of Home and Community-Based Services (HCBS) Settings*. A member's care plan must document the member's choice and/or placement in alternative HCBS settings. Should a member be transitioning from one setting to another setting, the person-centered planning process should address continuity of care and access to services during the transition. **Recommendations:** Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS revise its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. Additionally, the HCBS performance measures validated through the PMV activity do not have set MPSs and are not specifically addressed in HHS' MCO Quality Strategy. HHS should consider revising/updating its current Quality Strategy goals to include a measurable objective related to the HCBS performance measures. Alternatively, if HHS is not formally using the HCBS performance measures to measure and monitor MCO performance, HSAG recommends that HHS consider retiring these measures from the PMV activity and select new measures for validation that HHS can use to measure MCO	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	performance. Further, as the membership of Iowa's Managed Care Program will be redistributed when a new MCO joins the program effective July 1, 2023, HHS should closely monitor and immediately address with the MCOs, any disruption in services reported by members, family members, providers, and other stakeholders.	
Health Equity	**Conclusions:** HHS requested that the results of the MCO NAV activity include a stratified analysis of health equity by race/ethnicity, urbanicity, age, and a concentrated disadvantage index. The results of the MCO NAV activity demonstrated that 100 percent of members have access to an adult PCP; 100 percent of members have access to a pediatric PCP; 100 percent of members have access to a behavioral health inpatient provider; and almost 100 percent of members have access to a behavioral health outpatient provider. These results confirm there were no or minimal variations by member urbanicity, race/ethnicity, age, or living in an area of concentrated disadvantage. Additionally, HHS has implemented a pay-for-performance (P4P) program to reward the MCOs' efforts to improve quality and the health outcomes of members. The SFY 2022 program includes a performance measure related to the MCOs' health equity plans. To receive the incentive payment, the MCOs are required to submit a health equity plan that includes but is not limited to policies and procedures that demonstrate organizational attention to health equity focus areas; strategic goals; the measures and metrics used to track progress toward achieving the strategic goals; and measurement and evaluation of each strategic goal. Further, as demonstrated through the compliance review activity and quality assessment and performance improvement (QAPI) program, one MCO was a recipient of the National Committee for Quality Assurance (NCQA) Distinction in Multicultural Healthcare. Both MCOs also adhered to national culturally and linguistically appropriate services (CLAS) standards to identify and reduce care deficiencies related to CLAS and health disparities. **Recommendations:** Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS revise its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. Additionally, while HHS' contract with the PAHPs requires the PAHPs to deliver services to all members in a culturally competent manner, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity, it did not include any specific provisions addressing health equity in dental care. HHS could consider strengthening contract language to address health equity; for example, requiring the PAHPs to conduct an assessment of existing health disparities, including disparities identified through the results of performance measure reporting, and develop a formal health equity plan. HHS could also consider applying the MCO NAV activity methodology to the PAHP NAV activity and stratify PAHP results by race/ethnicity, urbanicity, age, and a concentrated disadvantage index.	
Voice of the Customer	**Conclusions:** HHS required the MCOs to conduct a PIP related to *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed.* Both MCOs received an overall validation status of *Met*, indicating the MCOs conducted appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement. While both MCOs demonstrated an increase in the *Customer Service at Child's Health Plan Gave Information or Help Needed* rate from the baseline rate to Remeasurement 1, the improvement was not statistically significant. However, Iowa Total Care did achieve programmatically significant improvement over the baseline performance through the implementation of after-call surveys and quality checks to ensure member services agents were performing as expected. The average score for the member services department increased by 2 percent from 2020 to 2021. HHS also requires the MCOs to report on their CAHPS data annually. Programwide rates indicate that no measure was statistically significantly lower than the 2021 national average. Further, rates for several measures were statistically significantly higher than the 2021 national average: *Getting Needed Care* and *Getting Care Quickly* for the adult population; and *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor* for the child population. Additionally, HHS requires the MCOs to conduct the Iowa Participant Experience Survey (IPES) for members receiving HCBS. It was confirmed through the compliance review activity and a review of Standard XIV—Quality Assessment and Performance Improvement Program that both MCOs implemented the IPES and reported the results to HHS quarterly. However, the programwide score for Standard X—Grievance and Appeal Systems	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	of the compliance review activity was 89 percent. All MCPs demonstrated opportunities to improve implementation of grievance and appeal processes to ensure adherence to all federal and State contract requirements. Strict adherence to these requirements is needed to ensure the MCPs collect complete and accurate information to review reports and make recommendations for improvement, including increasing member satisfaction when concerns are identified. **Recommendations:** Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS revise its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. Additionally, while HHS' contract with the PAHPs suggests that HHS will use the results of any member satisfaction surveys conducted by the PAHPs, HHS could strengthen contract language by requiring the PAHPs to conduct a member satisfaction survey annually. Additionally, as HHS' Quality Strategy for the PAHPs does not specifically address member satisfaction, HHS could consider setting a PAHP performance objective under the *Voice of the Customer* overarching goal.	

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

Overview of Managed Care Plans (MCPs)

During the CY 2022 review period, HHS contracted with two MCOs and two PAHPs. These MCPs are responsible for the provision of services to Iowa Medicaid and Hawki members. Table 2-1 provides a profile for each MCP.

Table 2-1—MCP Profiles

MCOs	Total Enrollment[2-2]	Covered Services[2-3]	Service Area
AGP	453,556	• 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	360,934		

2-1 Dental benefits offered through the Hawki program are administered by DDIA only. DWP Adults and DWP Kids benefits are administered by both DDIA and MCNA.

2-2 Iowa Department of Health and Human Services, Iowa Medicaid. *Medicaid Managed Care Monthly Reports, Monthly Demographic Reports*, December 2022. Available at: https://hhs.iowa.gov/sites/default/files/MCO_counts_December_2022.pdf Accessed on: Jan 22, 2023.

2-3 Iowa Department of Human Services. *Comparison of the State of Iowa Medicaid Enterprise Basic Benefits Based on Eligibility Determination.* Rev. 11/21. Available at: https://hhs.iowa.gov/sites/default/files/Comm519.pdf?092720211503. Accessed on: Jan 22, 2023.

PAHPs[2-1]	Total Enrollment[2-4]	Covered Services[2-5,2-6]	Service Area
DDIA	541,493	• 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	296,548		

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

Table 2-2—MCP Enrollment by Population[2-7,2-8]

MCP		Enrollment Population	Enrollment Count	Total Enrollment
MCOs	AGP	Medicaid	420,750	814,490
		Hawki	32,806	
		Total	**453,556**	
	ITC	Medicaid	346,753	
		Hawki	14,181	
		Total	**360,934**	
PAHPs	DDIA	DWP Adults	285,409	838,041
		DWP Kids	202,483	
		Hawki	53,601	
		Total	**541,493**	
	MCNA	DWP Adults	169,497	
		DWP Kids	127,051	
		Hawki	NA*	
		Total	**296,548**	

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

2-4 PAHP enrollment numbers (as of December 1, 2022) provided to HSAG by HHS.
2-5 State of Iowa Department of Health and Human Services. *Dental Wellness Plan Benefits*. Available at: https://hhs.iowa.gov/dental-wellness-plan/benefits. Accessed on: Jan 22, 2023.
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://hhs.iowa.gov/dental-wellness-plan/benefits.
2-7 State of Iowa Department of Health and Human Services, Iowa Medicaid. Medicaid Managed Care Monthly Reports, Monthly Demographic Reports, December 2022. Available at: https://hhs.iowa.gov/sites/default/files/MCO_counts_December_2022.pdf. Accessed on: Jan 22, 2023.
2-8 PAHP enrollment numbers (as of December 1, 2022) provided to HSAG by HHS.

Quality Strategy

The Iowa Medicaid Managed Care Quality Assurance System (Quality Strategy)[2-9,2-10] outlines HHS' 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. Table 2-3 and Table 2-4 present the Iowa Medicaid Managed Care Quality Assurance System goals for the MCOs and PAHPs, respectively.

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

Quality Strategy Goals
Behavioral Health
• Promote behavioral health by measuring follow-up after hospitalization/follow-up after emergency department visit (FUH/FUM) for pediatric and adult populations. The LTSS population, including Health Home members, will be stratified. • The State's EQR contractor, HSAG, will identify common behavioral health conditions, use of community services, follow-up care, and medication adherence. Once a baseline has been established, trends and recommendations for improvements will be identified. – Measure – Analyze – Suggest improvements • Promote mental health through the Integrated Health Home Program. • Assess the potential for an SUD Health Home Program. • University of Iowa pre-print measures follow-up after hospitalization for mental illness/ follow-up after emergency department visit for mental illness for adults and children.
Access to Care
• Increase covered lives in value-based purchasing arrangements at a minimum of 40%. • Improve network adequacy. • Improve timeliness of postpartum care. • Increase access to primary care and specialty care.
Program Administration
• Meet performance measures thresholds for timely claims reprocessing and encounter data. • Integrate the MCO quality plan with the quarterly MCO review process.

2-9 Iowa Department of Human Services. *Iowa Medicaid Managed Care Quality Assurance System*: 2021. Available at: https://hhs.iowa.gov/sites/default/files/2021_Quality_Plan.pdf?060120211735. Accessed on: Jan 22, 2023.

2-10 Iowa Department of Human Services Iowa Medicaid Enterprise. *Iowa Medicaid Dental Pre-Ambulatory Health Plan Quality Assurance System*: *2019*. Available at: https://hhs.iowa.gov/sites/default/files/2019%20Dental%20PAHP%20Quality%20Strategy.pdf?060520191449. Accessed on: Jan 22, 2023. Of note, the *Iowa Medicaid Dental Pre-Ambulatory Health Plan Quality Assurance System*: *2019* is currently under revision.

Quality Strategy Goals
Decrease Cost of Care
• Reduce the rate of potentially preventable readmissions and nonemergent ED visits.
Improving Coordinated Care
• 70% of HRAs will be completed within 90 days of enrollment and annually thereafter. • Improve the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes. • 100% timely completion of level of care and needs-based eligibility assessments. • 100% timely completion of the initial and annual service plan review and updates.
Continuity of Care
• Ensure the accuracy and completeness of member information needed to efficiently and effectively transition members between plans and/or providers. • Monitor long-term care facility documentation to ensure that members choosing to live in the community are able to successfully transition to, and remain in, the community (Minimum Data Set, Section Q, Intermediate Care Facility—Intellectual Disability discharge plans). • Monitor transition and discharge planning for LTSS members.
Health Equity
• Identify health disparities or inequities and target those areas for improvement. • Monitor the implementation and progress of the Health Equity Plans.
Voice of the Customer
• Annually, review the CAHPS results and make recommendations for improvement. • Quarterly, review the Home and Community-Based Services (HCBS) Iowa Participant Experience Survey (IPES) results and make recommendations for improvement. • Quarterly, review the appeals and grievance reports and make recommendations for improvement.

Table 2-4—Iowa Medicaid Managed Care Quality Assurance System—PAHPs

Quality Strategy Goals
• Promote appropriate utilization of services within acceptable standards of dental practice.
• Ensure access to cost-effective healthcare through contract compliance by: – Timely review of PAHP network adequacy reports. – Incentivizing access to preventive dental services.
• 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 PAHP quality strategies. – Quarterly reviewing PAHP quality meeting minutes.

Quality Strategy Goals
• Dental costs are reduced while quality is improved by: – Encouraging member engagement in dental care through completion of oral HRAs and a tiered benefit structure that expands benefits for members receiving preventive services.
• Provide care coordination to members based on HRAs by: – Monitoring HRA completion for members continuously enrolled for six months.
• Ensure that transitions of care do not have adverse effects by: – Maintaining historical utilization file transfers between HHS and the PAHPs, including the information needed to effectively transfer members.
• Promote healthcare quality standards in managed care programs by monitoring processes for improvement opportunities and assist PAHPs with implementation of improvement strategies through: – Regularly monitoring health outcomes measure performance.
• Ensure data collection related to race and ethnicity, as well as aid category, age, and gender in order to develop meaningful objectives for improvement in preventive and chronic 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.
• Promote the use and interoperability of health information technology between providers, PAHPs, and Medicaid.

Quality Initiatives

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

Health Equity Plan/P4P: As one of the MCP P4P measures, the Iowa Medicaid Quality Committee required each MCO to develop a Health Equity Plan to cover a three-year time frame (July 1, 2022–June 30, 2025). Areas of focus in these plans include diabetes, asthma, maternal child health, mental health and substance abuse disorders, coronavirus disease 2019 (COVID-19), and community integration. Draft plans were reviewed by the Quality Committee for inclusion of 10 required components, such as strategic goals, data streams, clear measures of success, and ongoing reviews for progress. The Quality Committee then provided MCOs with recommendations and required improvements to be implemented in order to finalize their plans. Implementation of each finalized plan will occur through June 30, 2025. Both medical MCPs finalized and implemented their own Health Equity Plans as of June 30, 2022. Each MCP is to provide quarterly updates to the Quality Committee regarding progress toward plan goals. In CY 2022, Amerigroup achieved NCQA's Multicultural Health Care Distinction. The Quality Committee will continue to monitor progress from both medical MCPs regarding their Health Equity Plan goals.

Medicaid Enterprise Modernization Effort (MEME) Project: Iowa has embarked on the Medicaid Enterprise Modernization Effort (MEME) project. This large, multi-year IT systems modernization initiative is focused on achieving outcomes supporting Medicaid strategic priority. Having a focus on buying measurable outcomes can generate dramatically improved results than requirements-based IT

procurement approaches from the past. This also aligns with the recent CMS move to Streamlined Modular Certification that likewise shifts to an outcomes-based mindset.

In this work, Iowa is seeking to deliver value (and learning) quickly in small, incremental steps to ensure actual implementation is tracking to match the intent of investments in IT. Empowerment of delivery teams, incorporation of end user input, rapid feedback, and transparency are also included. Iowa is beginning this process with a focus on delivering better provider outcomes through an improved, modernized enrollment process.

3. Assessment of Managed Care Organization Performance

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2022 review period to evaluate the performance of MCOs on providing quality, timely, and accessible healthcare services to Iowa 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. Timeliness refers to the elements defined under §438.68 (adherence to HHS' network adequacy standards) and §438.206 (adherence to HHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the MCOs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in CY 2022 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, refer to Appendix A.

Validation of Performance Improvement Projects

For the CY 2022 validation, the MCOs continued two HHS-mandated PIP topics, *Timeliness of Postpartum Care* and *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*, reporting Remeasurement 1 data for the performance indicators. HSAG conducted validation of the Implementation (Steps 7 and 8) and Outcomes (Step 9) stages for each PIP topic in accordance with the CMS' EQR protocol for validation of PIPs (CMS Protocol 1).

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

Table 3-1—PIP Topics and Performance Indicators

MCO	PIP Topic	Performance Indicator
AGP	*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 CAHPS child survey Question #45 (HHS 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 Service at Child's Health Plan gave help or information needed.

Performance Measure Validation

For the EQR time frame under evaluation, HSAG completed PMV activities for Amerigroup and Iowa Total Care for state fiscal year (SFY) 2022 (July 1, 2021–June 30, 2022).

Table 3-2 shows the list of performance measures and measurement periods evaluated in SFY 2022.

Table 3-2—Performance Measures for Validation

SFY 2022 Performance Measures Selected by HHS for Validation				
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 and ITC	July 1, 2021–June 30, 2022	Hybrid	HHS
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 and ITC	July 1, 2021–June 30, 2022	Hybrid	HHS
Provision of Care Plan The percentage of eligible members whose care plan was provided to all participants in the member's care team.	AGP and ITC	July 1, 2021–June 30, 2022	Hybrid	HHS
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 and ITC	July 1, 2021–June 30, 2022	Hybrid	HHS
Care Team Lead Chosen by the Member The percentage of eligible members who chose his or her own care team lead.	AGP and ITC	July 1, 2021–June 30, 2022	Hybrid	HHS
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 and ITC	July 1, 2021–June 30, 2022	Hybrid	HHS

HHS required each MCO to contract with an NCQA-certified HEDIS licensed organization to undergo a full audit of its HEDIS reporting process. As Iowa Total Care joined the Iowa Medicaid program in July 2019, data for HEDIS 2020 (MY 2019) are not available.

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

Table 3-3—HEDIS Measures

HEDIS Measure
Access to Preventive Care
Adults' Access to Preventive/Ambulatory Health Services
Ages 20–44 Years
Ages 45–64 Years
Ages 65 and Older
Use of Imaging Studies for Low Back Pain
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
BMI Percentile Documentation—Total
Counseling for Nutrition—Total
Counseling for Physical Activity—Total
Women's Health
Breast Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women—Total
Non-Recommended Cervical Cancer Screening in Adolescent Females
Prenatal and Postpartum Care
Timeliness of Prenatal Care
Postpartum Care
Living With Illness
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
Controlling High Blood Pressure
Statin Therapy for Patients With Cardiovascular Disease
Received Statin Therapy—Total
Statin Therapy for Patients With Diabetes

HEDIS Measure
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 Emergency Department (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
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
Child and Adolescent Well-Care Visits—Total
Childhood Immunization Status
Combination 3
Combination 10
Immunizations for Adolescents
Combination 1
Combination 2
Lead Screening in Children
Well-Child Visits in the First 30 Months of Life
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits
Medication Management
Adherence to Antipsychotic Medications for Individuals With Schizophrenia

HEDIS Measure
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 Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
Initiation Phase
Continuation and Maintenance Phase
Persistence of Beta-Blocker Treatment After a Heart Attack
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
Systemic Corticosteroid
Bronchodilator
Statin Therapy for Patients With Cardiovascular Disease
Statin Adherence 80%—Total
Statin Therapy for Patients With Diabetes
Statin Adherence 80%—Total
Use of Opioids at High Dosage
Use of Opioids From Multiple Providers
Multiple Prescribers
Multiple Pharmacies
Multiple Prescribers and Multiple Pharmacies

Compliance Review

CY 2021 commenced a new three-year cycle of compliance reviews. The compliance reviews for the HHS-contracted MCOs comprise 14 program areas, referred to as standards, that correlate to the federal standards and requirements identified in 42 CFR §438.358(b)(1)(iii). These standards also include applicable State-specific contract requirements and areas of focus identified by HHS. HSAG conducted a review of the first seven standards in Year One (CY 2021). For CY 2022, the remaining seven standards were reviewed (Year Two of the cycle). In Year Three (CY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the CY 2021 and CY 2022 compliance reviews. Table 3-4 outlines the standards reviewed over the three-year compliance review cycle. The compliance review activity was conducted in accordance with CMS' EQR protocol for the review of compliance with Medicaid and CHIP managed care regulations (CMS Protocol 3).

Table 3-4—Compliance Review Standards

Standards	Associated Federal Citations[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of MCO implementation of Year One and Year Two Corrective Action Plans (CAPs)
Standard II—Member Rights and Member Information	§438.10 §438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

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

[2] The Health Information Systems standard includes an assessment of each MCO's information system (IS) capabilities.

Network Adequacy Validation

The CY 2022 NAV activity evaluated members' access to PCPs and behavioral health providers. The analysis assessed the following dimensions of access to care:

- **Provider Capacity Analysis:** To assess the capacity of a given provider network, HSAG compared the number of PCP and behavioral health providers associated with each MCO's provider network relative to the number of enrolled members. This provider-to-member ratio represents a summary

statistic used to highlight the overall capacity of the MCO's provider network to deliver services to Medicaid recipients.

- **Percentage of members with access to PCPs:** This dimension assesses the percentage of members who had access to PCPs within the time/distance standard, including stratified analyses of health equities by race/ethnicity, urbanicity, age, and a concentrated disadvantage index.
- **Percentage of members with access to behavioral health providers:** This dimension calculates the percentage of members who had access to behavioral health providers within the time/distance standard, including stratified analyses of health equities by race/ethnicity, urbanicity, age, and a concentrated disadvantage index.

Encounter Data Validation

In CY 2022, HSAG conducted and completed EDV activities for the two MCOs. The EDV activities included:

- **Comparative analysis:** Analysis of HHS' electronic encounter data completeness and accuracy through a comparative analysis between HHS' electronic encounter data and the data extracted from the MCOs' data systems.
- **Technical assistance:** Follow-up assistance provided to the MCOs that performed poorly in the comparative analysis.
- **Medical record review (MRR):** Analysis of HHS' electronic encounter data completeness and accuracy through a comparison between HHS' electronic encounter data and the information documented in the corresponding members' medical records.

Consumer Assessment of Healthcare Providers and Systems Analysis

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The MCOs were responsible for obtaining CAHPS vendors to administer the CAHPS surveys on the MCOs' behalf. HSAG presents top-box scores, which indicate the percentage of members who responded to the survey with positive experiences in a particular aspect of their healthcare. Table 3-5 displays the various measures of member experience.

Table 3-5—CAHPS Measures of Member Experience

CAHPS Measures
Composite Measures
Getting Needed Care
Getting Care Quickly
How Well Doctors Communicate
Customer Service

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

Scorecard

HSAG analyzed MY 2021 HEDIS results and MY 2021 CAHPS data from the two MCOs, for presentation in the 2022 Iowa Medicaid Scorecard. MCO performance was evaluated in the following six reporting categories identified as important to consumers:

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

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

External Quality Review Activity Results

Amerigroup Iowa, Inc.

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of Amerigroup's PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-6 displays the overall validation status and the baseline and Remeasurement 1 results for each PIP topic.

Table 3-6—Overall Validation Rating for AGP

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
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.	68.9%	76.9% ↑	
CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	*Met*	The percentage of members who answer Amerigroup CAHPS child survey Question #45 (HHS Question #50): The Customer Service at a Child's Health Plan gave information or help needed, with a response of Usually or Always?	84.3%	92.9% ⇔	

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).

The goal for both PIPs is to demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-7 displays the interventions initiated by the MCO to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes for each PIP topic.

Table 3-7—Remeasurement 1 Interventions for AGP

Intervention Descriptions	
Timeliness of Postpartum Care	***CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed***
Telephonic outreach calls to eligible members who need a postpartum visit.	Manager audits post call survey alert calls and provides coaching, feedback, and additional training to customer service representatives.
Educated providers in a Provider Quality Incentive Program (PQIP) with a postpartum membership denominator greater than 30. The Missed Opportunity Report was used to identify assigned members and encourage providers to outreach these members to complete their postpartum visit within the HEDIS specification time frame after their delivery date.	Knowledge management audit conducted to ensure consistency and to reflect correct information. A lead was identified to monitor and ensure that information in knowledge management was correct and up to date.
Identified key provider sites to request remote access to their electronic medical record during the annual HEDIS hybrid project.	

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Amerigroup used appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement within its current processes. [**Quality**]

Strength #2: Amerigroup achieved statistically significant improvement over the baseline performance for the *Timeliness of Postpartum Care* PIP topic. Amerigroup implemented interventions to address identified barriers, including telephonic outreach to eligible members needing a postpartum visit, and conducted provider education and encouraged providers to outreach to members to complete a postpartum visit within the HEDIS specified time frame from their delivery date, which had a positive impact on Amerigroup's PIP results. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

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

Why the weakness exists: NA

Recommendation: NA

Performance Measure Validation

Performance Results

HSAG reviewed Amerigroup'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 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 significant concerns with Amerigroup's processes. Additionally, HSAG did not identify any issues during the PSV interview session, which included a focus on member-specific enrollment, claims, and case management data to support performance measures #1, 2, 3, 4, 5, and 6.

Table 3-8, Table 3-9, Table 3-10, and Table 3-11 show measure designation and reportable measure rates for SFY 2022. While individual rates are produced for each of the eight waiver populations, only the aggregate rate is displayed. Amerigroup received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 3-8—SFY 2022 #1a Performance Measure Designation and Rates for AGP*

Performance Measure		Measure Designation	Measure Rate				
			0%	1–49%	50–74%	75–89%	90–100%
1a	*Percentage of Eligible Members With Applicable Percentage of Authorized Services Utilized*	*R*	12.86%	50.80%	22.72%	9.20%	4.41%

* Rates are provided for information only.

Table 3-9—SFY 2022 #1b Performance Measure Designation and Rates for AGP*

Performance Measure		Measure Designation	Measure Rate
1b	*The Percentage of Eligible Members for Whom 100 Percent of HCBS Documented in Members' Care Plans Had a Corresponding Approved Service Authorization*	*R*	80.66%

* Rates are provided for information only.

Table 3-10—SFY 2022 #2 Performance Measure Designation and Rates for AGP*

Performance Measure		Measure Designation	Measure Results		
			Denominator	Numerator	Rate
2a	*Members With One or More Documented Care Plan One-Time Service*	*R*	1,065	18	1.69%
2b	*Members With Documented Care Plan One-Time Service With Corresponding Approved Service Authorization*	*R*	18	6	33.33%
2c	*Percentage of Authorized One-Time Services Utilized*	*R*	8	1	12.50%

* Rates are provided for information only.

Table 3-11—SFY 2022 #3, #4, #5, and #6 Performance Measure Designation and Rates for AGP

Performance Measure		Measure Designation	Measure Results		
			Denominator	Numerator	Rate
3	*Provision of Care Plan*	*R*	1,575	1,050	66.67%
4	*Person-Centered Care Plan Meeting**	*R*	1,575	1,247	79.17%
5	*Care Team Lead Chosen by the Member*	*R*	1,575	1,237	78.54%
6	*Member Choice of HCBS Settings*	*R*	1,575	1,535	97.46%

* 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

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

Strengths

Strength #1: Amerigroup continued to use a flexible approach to ensuring the health and safety of its LTSS members throughout the COVID-19 public health emergency (PHE). Amerigroup continued to authorize services that were more widely available for consumers in home environments while still finding ways to maintain flexibility, such as allowing and encouraging the

use of consumer-directed attendant care (CDAC) agreements to allow family members to be paid for providing services in the home. Amerigroup closely monitored utilization to ensure consumers were able to access services and watched for adjustments that were needed due to limited service availability and/or provider staffing issues in certain areas. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Amerigroup's performance improved on measures 3 through 6 in SFY 2022 in comparison to SFY 2021. Amerigroup identified updates to the person care service plan (PCSP) template for integrated health home (IHH) members, use of a follow-up reminder task to improve distribution of the care plan to members, and a focus on these measures during monthly auditing in the LTSS department as the primary interventions that improved the rates. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Amerigroup did not include encounter data from its waiver transportation vendor in preliminary rates for measure 1. [**Quality**]

Why the weakness exists: Amerigroup reported that waiver transportation encounters were stored in a separate table within the data warehouse and the encounters were not integrated with the other HCBS claims data during the preliminary measure production process.

Recommendation: HSAG recommends that Amerigroup work with its waiver transportation vendor to identify waiver transportation encounters in the encounter data files received monthly so the encounters can be integrated with other LTSS claims during the measure production process.

Weakness #2: Amerigroup continued to rely wholly on clinical abstraction of care coordination and service plan records and was unable to monitor performance on measures 3 through 6 for any of the LTSS members during the measurement year to address deficiencies in cases prior to measure rate production. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Amerigroup's care coordination system, Healthy Innovation Platform (HIP), currently houses service plan data in PDF forms that do not allow reportable fields. The forms must be audited to determine compliance for the performance measures, and the LTSS team audited one case per community-based case manager (CBCM) per quarter.

Recommendation: Amerigroup should consider implementing a monitoring process that makes visible the status of all LTSS members on the performance measures. It could consider a process that involves CBCM or clerical data entry on a centralized shared file following completion of care planning activities, which could be used to track compliance throughout the measurement year. Additionally, as previously recommended, Amerigroup should consider initiating an information technology (IT) project to create reportable fields within the HIP platform service plan and contact forms and provide its analytics team with back-end access to the platform to extract the data using structured query language (SQL) code as used for measures 1 and 2. This investment of IT resources would likely create savings over the long term through preserving clinical staff time for clinical activities. It would also allow for future capabilities to report the data administratively for the sampled records, removing the need to manually abstract all of the data for performance measure reporting.

Performance Results—HEDIS

HSAG's review of the Final Audit Report (FAR) for HEDIS MY 2021 showed that Amerigroup's HEDIS compliance auditor found Amerigroup's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. Amerigroup contracted with an external software vendor with HEDIS Certified Measures℠[3-1] for measure production and rate calculation.

Table 3-12—HEDIS MY 2021 Results for AGP

Measures	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Three-Year Trend	Star Rating
Access to Preventive Care					
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	84.13%	80.59%	79.78%	↓	★★★★
45–64 Years	88.97%	85.27%	85.53%	↓	★★★
65 Years and Older	90.43%	78.06%	89.64%	↓	★★★★
Use of Imaging Studies for Low Back Pain					
Use of Imaging Studies for Low Back Pain	71.72%	70.97%	70.49%	↓	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile Documentation—Total	78.83%	72.02%	71.78%	↓	★★
Counseling for Nutrition—Total	65.45%	65.69%	64.96%	↓	★★
Counseling for Physical Activity—Total	62.77%	61.07%	62.53%	↓	★★
Women's Health					
Breast Cancer Screening					
Breast Cancer Screening	55.96%	53.59%	52.72%	↓	★★
Cervical Cancer Screening					
Cervical Cancer Screening	63.02%	60.10%	59.12%	↓	★★★
Chlamydia Screening in Women					
Total	48.50%	44.86%	45.22%	↓	★
Non-Recommended Cervical Cancer Screening in Adolescent Females*					
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.28%	0.21%	0.27%	↑	★★★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	86.60%	78.10%	81.51%	↓	★★
Postpartum Care	62.63%	68.86%	76.89%	↑	★★★

[3-1] HEDIS Certified Measures℠ is a service mark of the NCQA

Measures	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Three-Year Trend	Star Rating
Living With Illness					
Comprehensive Diabetes Care					
HbA1c Testing	91.48%	89.54%	88.32%	↓	★★★★★
HbA1c Control (<8.0%)	59.85%	46.47%	48.42%	↓	★★★
*HbA1c Poor Control (>9.0%)**	27.98%	42.34%	42.34%	↓	★★★
Blood Pressure Control (<140/90 mm Hg)	—	72.26%	71.29%	—	★★★★★
Eye Exam (Retinal) Performed	61.31%	55.47%	54.99%	↓	★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	65.69%	64.23%	—	★★★★
Statin Therapy for Patients With Cardiovascular Disease					
Received Statin Therapy—Total	72.07%	81.21%	80.24%	↑	★★
Statin Therapy for Patients With Diabetes					
Received Statin Therapy	62.20%	68.81%	66.53%	↑	★★★
Behavioral Health					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	67.17%	70.55%	72.32%	↑	★★★★
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	77.62%	74.63%	79.11%	↑	★★★
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence					
7 Day Follow-Up—Total	48.88%	46.06%	50.53%	↑	★★★★★
30 Day Follow-Up—Total	55.19%	53.41%	56.33%	↑	★★★★★
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—Total	67.82%	64.60%	67.10%	↓	★★★★★
30-Day Follow-Up—Total	77.51%	75.90%	77.99%	↑	★★★★★
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	47.54%	48.83%	57.61%	↑	★★★★★
30-Day Follow-Up—Total	69.03%	69.37%	75.50%	↑	★★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment					
Initiation of AOD Treatment—Total	74.22%	69.95%	74.64%	↑	★★★★★

Measures	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Three-Year Trend	Star Rating
Engagement of AOD Treatment—Total	29.04%	26.21%	27.77%	↓	★★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose and Cholesterol Testing–Total	27.35%	23.12%	24.68%	↓	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	66.79%	58.96%	62.73%	↓	★★
Keeping Kids Healthy					
Childhood Immunization Status					
Combination 3	76.89%	75.43%	73.24%	↓	★★★★
Combination 10	46.47%	51.58%	49.15%	↑	★★★★
Immunizations for Adolescents					
Combination 1	87.83%	88.81%	85.89%	↓	★★★
Combination 2	37.47%	31.39%	35.77%	↓	★★
Lead Screening in Children					
Lead Screening in Children	81.02%	82.00%	77.62%	↓	★★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	46.91%	60.51%	—	★★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	70.09%	70.08%	—	★★
Child and Adolescent Well-Care Visits					
Total	—	45.54%	49.75%	—	★★★
Medication Management					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.27%	67.62%	64.67%	↓	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	51.71%	52.94%	60.15%	↑	★★★
Effective Continuation Phase Treatment	35.77%	37.41%	42.52%	↑	★★★
Appropriate Testing for Pharyngitis					
Total	81.34%	80.59%	78.09%	↓	★★★
Appropriate Treatment for Upper Respiratory Infection					
Total	84.16%	85.99%	90.21%	↑	★★★

Measures	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Three-Year Trend	Star Rating
Asthma Medication Ratio					
Total	60.64%	66.94%	70.27%	↑	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Total	43.43%	47.06%	46.65%	↑	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	41.65%	42.87%	43.41%	↑	★★
Continuation and Maintenance Phase	51.02%	45.50%	47.83%	↓	★★
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	86.67%	78.28%	81.19%	↓	★★
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	59.27%	74.41%	72.33%	↑	★★★
Bronchodilator	69.47%	83.39%	81.67%	↑	★★
Statin Therapy for Patients With Cardiovascular Disease					
Statin Adherence 80%—Total	68.66%	72.84%	69.30%	↑	★★
Statin Therapy for Patients With Diabetes					
Statin Adherence 80%—Total	65.14%	70.34%	68.86%	↑	★★★
Use of Opioids at High Dosage*					
Use of Opioids at High Dosage	3.16%	2.64%	2.07%	↑	★★★★
Use of Opioids From Multiple Providers*					
Multiple Prescribers	20.67%	16.59%	18.27%	↑	★★★
Multiple Pharmacies	3.06%	1.40%	1.07%	↑	★★★★★
Multiple Prescribers and Multiple Pharmacies	2.11%	1.04%	0.81%	↑	★★★★

* For this indicator, a lower rate indicates better performance.
— Indicates that the 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 rate is not displayed.
^ In alignment with HHS and NCQA guidance, HEDIS 2020 (MY 2019) results for this measure were rotated with the HEDIS 2019 (MY 2018) hybrid rate.
± Due to changes in the technical specifications for this measure, exercise caution when trending rates.
↓ Indicates performance worsened over a three-year time period.
↑ Indicates performance improved over a three-year time period.
HEDIS MY 2021 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★= At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Amerigroup's performance in the Women's Health and Keeping Kids Healthy domains improved notably this year in several areas. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator improved to finish at or above the 25th percentile but below the 50th percentile, and the *Prenatal and Postpartum Care—Postpartum Care* indicator improved to finish at or above the 50th percentile but below the 75th percentile. The *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator showed a gain of nearly 14 percentage points to finish at or above the 50th percentile but below the 75th percentile, and the *Child and Adolescent Well-Care Visits* measure showed a gain of 4 percentage points to also finish at or above the 50th percentile but below the 75th percentile. [**Timeliness** and **Access**]

Strength #2: Amerigroup's performance in the Behavioral Health and Medication Management domains improved this year in several areas. The *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure improved to a rate at or above the 75th percentile but below the 90th percentile, while the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure improved to a rate at or above the 50th percentile but below the 75th percentile. The *Follow-Up After Hospitalization for Mental Illness* measure improved to rates at or above the 90th percentile for both seven- and 30-day indicators. Both indicators of the *Antidepressant Medication Management* measure and the *Appropriate Treatment for Upper Respiratory Infection* measure improved to rates at or above the 50th percentile but below the 75th percentile. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Amerigroup's performance under the Women's Health domain ranked below the 25th percentile for the *Chlamydia Screening in Women* measure, indicating that a large number of women were not being seen or screened by their providers. Untreated chlamydia infections can lead to serious and irreversible complications. [**Quality**, **Timeliness** and **Access**]

Why the weakness exists: The low rate for *Chlamydia Screening in Women* suggests that barriers continue to exist for sexually active women between 16 and 24 years of age to access this important health screening. Although Amerigroup conducted an educational campaign with providers and determined that providers are following national standards, it appears that women in this age range are not comfortable reporting sexual activity to their provider.

Recommendation: Amerigroup may want to consider an educational campaign targeted at members in this age group that emphasizes the importance of screening for sexual health and family planning.

Amerigroup is recommended to work with providers on educational efforts, as materials may be most effective when distributed by providers in conjunction with office visits. Additionally, Amerigroup is recommended to review satisfaction survey results of providers who have noncompliant members in the measure to determine if members may not feel comfortable sharing certain information with them due to cultural competency issues.

Weakness #2: Amerigroup's performance under the Behavioral Health domain ranked below the 25th percentile again this year for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing*. These low rates indicate that patients receiving behavioral health treatment using antipsychotic medication were not always being screened or monitored properly. Monitoring of blood glucose and cholesterol testing are important components of ensuring appropriate management of children and adolescents on antipsychotic medications due to the potential side effects of these medications. [**Quality**]

Why the weakness exists: Low rates suggest that there are barriers to appropriate monitoring for adults and children with severe and persistent mental illness who are being treated with psychotropic medication, potentially with behavioral health providers not ordering the correct tests for monitoring.

Recommendation: HSAG recommends that Amerigroup partner with providers to determine why some members with severe mental illnesses are not being monitored for diabetes or for metabolic functioning, such as by providing education and assistance when needed to ensure behavioral health providers understand which tests to monitor and how to access lab testing. Amerigroup should continue to work with providers to implement appropriate interventions (e.g., process improvements, patient education campaign, and provider incentives) to improve the performance rates of these measures.

Compliance Review

Performance Results

Table 3-13 presents Amerigroup's compliance scores for each standard evaluated during the current three-year compliance review cycle. Amerigroup was required to submit a CAP for all standards scoring less than 100 percent compliant. Amerigroup's implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-13—Standard Compliance Scores AGP

Compliance Review Standards	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (CY 2021)		
Standard I—Disenrollment: Requirements and Limitations	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**80%**

Compliance Review Standards	Associated Federal Citations[1]	Compliance Score
Standard III—Emergency and Poststabilization Services	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**100%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**
Standard VI—Coordination and Continuity of Care	§438.208	**90%**
Standard VII—Coverage and Authorization of Services	§438.210	**80%**
Year Two (CY 2022)		
Standard VIII—Provider Selection	§438.214	**79%**
Standard IX—Confidentiality	§438.224	**92%**
Standard X—Grievance and Appeal Systems	§438.228	**87%**
Standard XI—Subcontractual Relationships and Delegation	§438.230	**85%**
Standard XII—Practice Guidelines	§438.236	**100%**
Standard XIII—Health Information Systems[2]	§438.242	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	**93%**
Year Three (CY 2023)		
Review of MCO implementation of Year One and Year Two CAPs		

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

[2] The Health Information Systems standard includes an assessment of the MCO's IS capabilities.

Table 3-14 presents Amerigroup's scores for each standard evaluated during the CY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in Amerigroup's written documents, including policies, procedures, reports, and meeting minutes; and interviews with MCO staff members. The CY 2022 Compliance Review activity demonstrated how successful Amerigroup was in interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with HHS.

Table 3-14—CY 2022 Standard Compliance Scores for AGP

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	14	14	11	3	0	**79%**
Standard IX—Confidentiality	12	12	11	1	0	**92%**
Standard X—Grievance and Appeal Systems	38	38	33	5	0	**87%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard XI—Subcontractual Relationships and Delegation	13	13	11	2	0	**85%**
Standard XII—Practice Guidelines	6	6	6	0	0	**100%**
Standard XIII—Health Information Systems[1]	9	9	9	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	30	30	28	2	0	**93%**
Total	**122**	**122**	**109**	**13**	**0**	**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.
[1] The Health Information Systems standard included an assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Amerigroup achieved full compliance in the Practice Guidelines program area, demonstrating that the MCO adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines. [**Quality** and **Access**]

Strength #2: Amerigroup achieved full compliance in the Health Information Systems program area, demonstrating that the MCO maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Amerigroup received a score of 79 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed and recredentialed in accordance with contractual requirements. [**Quality**]

Why the weakness exists: Amerigroup did not meet the State's required credentialing standards as timely credentialing notification letters were not sent. Additionally, the MCO was not calculating credentialing completion time frames in accordance with HHS' specifications.

Recommendation: Amerigroup was required to develop a CAP which was subsequently approved by HHS. HSAG recommends that the MCO ensure processes are in place to fully implement its CAP and remediate any deficiencies noted through the compliance review activity.

Network Adequacy Validation

Performance Results

Table 3-15 illustrates the number of unique providers in the Amerigroup network (enrolled as of July 31, 2022), as well as provider-to-member ratios for adult and pediatric member populations across primary and behavioral healthcare. Table 3-16 demonstrates that 100 percent of adult and pediatric members had access to PCPs within the time/distance standard. Table 3-17 demonstrates the percentage of adult and pediatric members who had access to behavioral health providers within the time/distance standard for Amerigroup.

Table 3-15—Provider Capacity Analysis for Medicaid and Hawki Members for Amerigroup

Provider Category	Medicaid		Hawki	
	Number of Unique Providers	Provider-to-Member Ratio	Number of Unique Providers	Provider-to-Member Ratio
Primary Care Provider				
Primary Care Provider—Adult	4,933	1:49	NA	NA
Primary Care Provider—Pediatric	3,842	1:47	3,842	1:10
Behavioral Health Provider				
Behavioral Health Provider, Inpatient	108	1:3,880	108	1:337
Behavioral Health Provider, Outpatient	3,662	1:115	3,662	1:10

NA: Not applicable

Table 3-16—Percentage of Members With Access to PCPs Within Time/Distance Standards for Amerigroup

Percentage of Members With Access to Primary Care Providers Within the Time/Distance Standards (30 miles or 30 minutes)			
Stratification	**Adult Members**	**Pediatric Members**	
	Medicaid	**Medicaid**	**Hawki**
Urbanicity			
Urban	100.0%	100.0%	100.0%
Rural	100.0%	100.0%	100.0%
Concentrated Disadvantage Index			
No	100.0%	100.0%	100.0%
Yes	100.0%	100.0%	100.0%
Age Category			
18 and Under	NA	100.0%	100.0%
19 to 64 years	100.0%	NA	NA
65 and Older	100.0%	NA	NA
Race/Ethnicity			
American Indian or Alaska Native	100.0%	100.0%	100.0%
Asian	100.0%	100.0%	100.0%
Black or African American	100.0%	100.0%	100.0%
*Hispanic**	100.0%	100.0%	100.0%
Two or More Races	100.0%	100.0%	100.0%
Native Hawaiian and Other Pacific Islander	100.0%	100.0%	100.0%
Unknown	100.0%	100.0%	100.0%
White	100.0%	100.0%	100.0%
Overall			
Overall	100.0%	100.0%	100.0%

NA: Not applicable

*Those identified as Hispanic can be of any race or combination of races. All other categories except Unknown are non-Hispanic.

Table 3-17—Percentage of Members With Access to Behavioral Health Providers Within Time/Distance Standards for Amerigroup

Percentage of Members With Access to Behavioral Health Providers Within the Time/Distance Standards				
Stratification	Inpatient BH Providers		Outpatient BH Providers	
	Medicaid	Hawki	Medicaid	Hawki
Urbanicity				
Urban	100.0%	100.0%	100.0%	100.0%
Rural	100.0%	100.0%	100.0%	100.0%
Concentrated Disadvantage Index				
No	100.0%	100.0%	100.0%	100.0%
Yes	100.0%	100.0%	100.0%	100.0%
Age Category				
18 and Under	100.0%	100.0%	100.0%	100.0%
19 to 64 years	100.0%	NA	100.0%	NA
65 and Older	100.0%	NA	100.0%	NA
Race				
American Indian or Alaska Native	100.0%	100.0%	100.0%	100.0%
Asian	100.0%	100.0%	100.0%	100.0%
Black or African American	100.0%	100.0%	100.0%	100.0%
*Hispanic**	100.0%	100.0%	100.0%	100.0%
Two or More Races	100.0%	100.0%	100.0%	100.0%
Native Hawaiian and Other Pacific Islander	100.0%	100.0%	100.0%	100.0%
Unknown	100.0%	100.0%	100.0%	100.0%
White	100.0%	100.0%	100.0%	100.0%
Overall				
Overall	100.0%	100.0%	100.0%	100.0%

NA: Not applicable

*Those identified as Hispanic can be of any race or combination of races. All other categories except Unknown are non-Hispanic.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Amerigroup met all time/distance requirements for primary care and behavioral health providers. The access to providers did not vary by member urbanicity, race/ethnicity, age, or living in an area of concentrated disadvantage.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for Amerigroup through the NAV activity.

Why the weakness exists: NA

Recommendation: NA

Encounter Data Validation

Performance Results—Medical Record Review

Table 3-18 presents the percentage of medical record documentation submissions, and Table 3-19 presents the major reasons medical record documentation was not submitted by Amerigroup.

Table 3-18—Summary of Medical Records Requested and Received for AGP

MCO	Number of Records Requested	Records Submitted		Records Submitted With Second Date of Service	
		Number	Percent[1]	Number	Percent[2]
Amerigroup	411	230	56.0%	123	53.5%

[1] Percent was calculated based on number of records requested and number of records submitted.
[2] Percent was calculated based on number of records submitted and number of records submitted with second date of service.

Table 3-19—Reasons Medical Records Were Not Submitted for Date of Service for AGP

Reason	Number	Percent
Record not located at this facility; location unknown	0	0.0%
Member is a patient of the practice; however, no documentation was available for requested dates of service	0	0.0%

Reason	Number	Percent
Member is not a patient of this practice	1	0.6%
Non-responsive provider or provider did not respond in a timely manner	97	53.6%
Provider refused to release record	0	0.0%
Facility is permanently closed; unable to procure record	0	0.0%
Other*	83	45.9%
Total**	**181**	**100.0%**

* Amerigroup selected "Other" as one of its reasons for not submitting the requested medical records. Amerigroup noted within the tracking sheets in its response for selecting "Other" that 56 requested records had no medical record available, 14 had no patient visit, seven had dates of service that were outside of the study period, five had no explanation for non-submission, and one noted that the patient did not receive service on the requested date of service.

** The sum of the percentages of all non-submission reasons may not equal 100 percent due to rounding.

Table 3-20 displays the medical record omission, encounter data omission, element accuracy, and all-element accuracy rates for each key data element.

Table 3-20—Encounter Data Completeness and Accuracy Summary for AGP

Key Data Element	Medical Record Omission[1]	Encounter Data Omission[2]	Element Accuracy[3]	Inaccuracy Reasons
Date of Service	39.5%	7.9%	—	—
Diagnosis Code	42.5%	3.9%	100.0%	1. Inaccurate Code (0.0%) 2. Specificity Error (0.0%)
Procedure Code	38.3%	6.7%	96.8%	1. Inaccurate Code (100.0%) 2. Higher Level of Service in Medical Record (0.0%) 3. Lower Level of Service in Medical Record (0.0%)
Procedure Code Modifier	48.3%	5.4%	100.0%	—
All-Element Accuracy[4]			81.1%	—

"—" Denotes that the error type analysis was not applicable to a given data element.

[1] Services documented in the encounter data but not supported by the members' medical records. Lower rate values indicate better performance.

[2] Services documented in the members' medical records but not in the encounter data. Lower rate values indicate better performance.

[3] Services documented in the members' medical records associated with validated dates of service from the encounter data that were correctly coded based on the medical records. Higher rate values indicate better performance.

[4] The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate from each data element.

Strengths, Weaknesses, and Recommendations–Medical Record Review

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

Strengths

Strength #1: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate, each with rates of at least 96.0 percent.

Weaknesses and Recommendations

Weakness #1: Amerigroup was unable to procure all requested medical records from its contracted providers due to providers being non-responsive or not responding in a timely manner, or for other reasons wherein Amerigroup indicated that the majority were due to no documentation/medical records being available for the requested dates of service.

Why the weakness exists: The non-submission reason for non-responsive providers or providers who did not respond in a timely manner may indicate that the contracted providers were unaware of the submission requirements or the deadline.

Recommendation: Amerigroup should ensure its contracted providers' accountability in responding to medical record requests for auditing, inspection, and oversight. HSAG recommends that Amerigroup consider strengthening and/or enforcing contract requirements with its providers in supplying the requested documentation.

Weakness #2: No documentation/medical records were available for the selected members' dates of service.

Why the weakness exists: The non-submission reason noted by Amerigroup's provider may indicate inconsistencies between the information stored in the provider's office versus HHS' encounter data or that an encounter was submitted to HHS even though a member did not access care.

Recommendation: Amerigroup should investigate and follow up with its providers to determine why encounters were submitted to HHS but no documentation/medical records were available for the requested dates of service. Based on the findings, Amerigroup should consider taking additional action, as appropriate (e.g., request overpayment of funds).

Weakness #3: The medical record omission rates (i.e., data elements in the encounter data were not supported by members' medical records) were high for all data elements.

Why the weakness exists: Factors contributing to key data elements not being supported by the members' medical records may have been due to medical records not being submitted or providers not documenting the services in the medical records despite submitting a claim or encounter.

Recommendation: As noted previously, Amerigroup should ensure its contracted providers' accountability in responding to medical record requests for auditing, inspection, and oversight. Amerigroup should also consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews would then be shared with providers through periodic education and training regarding data submissions, medical record documentation, and coding practices.

Performance Results—Comparative Analysis

There are two aspects of record completeness—record omission and record surplus. Table 3-21 displays the percentage of records present in the files submitted by Amerigroup that were not found in the HHS-submitted files (record omission), and the percentage of records present in the HHS-submitted files but not present in Amerigroup-submitted files (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 3-21—Record Omission and Surplus Rates for AGP

Encounter Type	Record Omission	Record Surplus
Professional	4.2%	1.0%
Institutional	2.0%	0.6%
Pharmacy	0.4%	1.8%

Table 3-22 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the professional encounters for Amerigroup. For the element omission and surplus indicators, lower rates indicate better performance, whereas for the element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, neither lower nor higher rates indicate better or worse performance.

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

Key Data Elements*	Element Omission	Element Surplus	Element Absent	Element Accuracy
Member ID	0.0%	0.0%	0.0%	100.0%
Detail Service From Date	0.0%	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	0.0%	97.3%
Billing Provider NPI	0.0%	<0.1%	0.0%	>99.9%
Rendering Provider NPI	0.0%	<0.1%	0.0%	99.7%
Referring Provider NPI[1]	<0.1%	1.3%	61.8%	100.0%
Primary Diagnosis Code	0.0%	0.0%	0.0%	100.0%
Secondary Diagnosis Code[1]	0.0%	0.0%	54.5%	100.0%
CDT/CPT/HCPCS Procedure Code	0.0%	0.0%	0.0%	100.0%
Procedure Code Modifier[1]	0.0%	0.0%	52.8%	100.0%
Units of Service[2]	0.0%	0.0%	0.0%	79.6%

Key Data Elements*	Element Omission	Element Surplus	Element Absent	Element Accuracy
NDC[1]	0.0%	0.0%	94.8%	100.0%
Detail Paid Amount	0.0%	0.0%	0.0%	92.6%

* NPI = National Provider Identifier; CDT = Current Dental Terminology; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code

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

[2] HHS noted that remediation of the *Units of Service* data element being captured appropriately within the Medicaid Management Information System (MMIS) was completed as of August 2021 for Amerigroup's encounter submission. However, since the dates of service evaluated for the study included dates prior to August 2021, issues were still observed for the analysis (i.e., element accuracy).

Table 3-23 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the institutional encounters for Amerigroup. For the element omission and surplus indicators, lower rates indicate better performance, whereas for the element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, neither lower nor higher rates indicate better or worse performance.

Table 3-23—Data Element Omission, Surplus, Absent, and Accuracy: Institutional Encounters for AGP

Key Data Elements*	Element Omission	Element Surplus	Element Absent	Element Accuracy
Member ID	0.0%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	100.0%
Header Service To Date	0.0%	0.0%	0.0%	100.0%
Admission Date[1]	0.0%	0.0%	80.0%	>99.9%
Billing Provider NPI	0.0%	0.0%	0.0%	>99.9%
Attending Provider NPI	0.0%	0.0%	<0.1%	100.0%
Referring Provider NPI[1]	0.0%	0.0%	96.3%	100.0%
Primary Diagnosis Code	0.0%	0.0%	0.0%	100.0%
Secondary Diagnosis Code[1]	0.0%	0.0%	17.1%	100.0%
CDT/CPT/HCPCS Procedure Code[1]	0.1%	0.0%	15.4%	100.0%
Procedure Code Modifier[1]	0.0%	0.0%	75.5%	100.0%
Units of Service[2]	0.0%	0.0%	0.0%	48.4%
Primary Surgical Procedure Code[1]	0.7%	0.4%	95.3%	100.0%
Secondary Surgical Procedure Code[1]	0.5%	0.3%	96.9%	99.9%
NDC[1]	0.0%	0.0%	89.0%	100.0%
Revenue Code	0.0%	0.0%	0.0%	99.9%
DRG Code[1]	<0.1%	0.0%	92.4%	99.2%

Key Data Elements*	Element Omission	Element Surplus	Element Absent	Element Accuracy
Header Paid Amount	0.0%	0.0%	0.0%	96.1%
Detail Paid Amount	0.0%	0.0%	0.0%	97.9%

* NPI = National Provider Identifier; CDT = Current Dental Terminology; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code; DRG = Diagnosis Related Group

[1] *Admission Date*, *Referring Provider NPI*, *Secondary Diagnosis Code*, *CDT/CPT/HCPCS 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 encounter transaction).

[2] HHS noted that remediation of the *Units of Service* data element being captured appropriately within MMIS was completed as of August 2021 for Amerigroup's encounter submission. However, since the dates of service evaluated for the study included dates prior to August 2021, issues were still observed for the analysis (i.e., element accuracy).

Table 3-24 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the pharmacy encounters for Amerigroup. 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, neither lower nor higher rates indicate better or worse performance.

Table 3-24—Data Element Omission, Surplus, Absent, and Accuracy: Pharmacy Encounters for AGP

Key Data Elements*	Element Omission	Element Surplus	Element Absent	Element Accuracy
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%	0.1%	0.0%	>99.9%
NDC	0.0%	0.0%	0.0%	99.8%
Drug Quantity	0.1%	0.0%	0.0%	99.4%
Header Paid Amount	0.0%	0.0%	0.0%	100.0%
Dispensing Fee	0.0%	0.0%	0.0%	100.0%

* NPI = National Provider Identifier; NDC = National Drug Code

Table 3-25 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. For the all-element accuracy indicator, higher rates indicate better performance.

Table 3-25—All-Element Accuracy and Encounter Type for AGP

Professional Encounters	Institutional Encounters	Pharmacy Encounters
69.7%	45.6%	99.0%

Strengths, Weaknesses, and Recommendations—Comparative Analysis

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

Strengths

Strength #1: Amerigroup's professional, institutional, and pharmacy encounters exhibited complete data with low record omission and record surplus rates.

Strength #2: Among encounters that could be matched between data extracted from HHS' data warehouse and data extracted from Amerigroup's data system, a high level of element completeness (i.e., low element omission and surplus rates) was exhibited.

Strength #3: 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, with very few exceptions.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for Amerigroup through the EDV activity.

Why the weakness exists: NA

Recommendation: NA

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-26 presents Amerigroup's 2022 adult Medicaid, general child Medicaid, and children with chronic conditions (CCC) Medicaid CAHPS top-box scores. Arrows (↓ or ↑) indicate 2022 scores that were statistically significantly higher or lower than the 2021 national average.

Table 3-26—Summary of 2022 CAHPS Top-Box Scores for AGP

	2022 Adult Medicaid	2022 General Child Medicaid	2022 CCC Medicaid Supplemental
Composite Measures			
Getting Needed Care	86.0% ↑	90.1% ↑	91.8% ↑
Getting Care Quickly	85.8% ↑	91.7% ↑	91.6%

	2022 Adult Medicaid	2022 General Child Medicaid	2022 CCC Medicaid Supplemental
How Well Doctors Communicate	93.7%	96.5% ↑	96.8% ↑
Customer Service	NA	NA	NA
Global Ratings			
Rating of All Health Care	55.1%	74.1%	68.3%
Rating of Personal Doctor	70.6%	82.5% ↑	76.5%
Rating of Specialist Seen Most Often	67.1%	76.5%	79.7%
Rating of Health Plan	61.1%	73.6%	67.9%
Effectiveness of Care Measures*			
Advising Smokers and Tobacco Users to Quit	69.3%		
Discussing Cessation Medications	42.6% ↓		
Discussing Cessation Strategies	38.2% ↓		
CCC Composite Measures/Items			
Access to Specialized Services			NA
Family Centered Care (FCC): Personal Doctor Who Knows Child			91.7%
Coordination of Care for Children With Chronic Conditions			71.5%
Access to Prescription Medicines			93.5%
FCC: Getting Needed Information			93.5%

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

↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.

↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Adult members had positive experiences with getting the care they needed and getting it quickly as the scores for the *Getting Needed Care* and *Getting Care Quickly* measures were statistically significantly higher than the 2021 NCQA adult Medicaid national averages. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Parents/caretakers of child members in the general child population had positive experiences with getting the care their child needed, getting care for their child quickly, and their child's personal doctor, including communication, as the scores for the *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Personal Doctor* measures were statistically significantly higher than the 2021 NCQA child Medicaid national averages. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Parents/caretakers of child members in the CCC population had positive experiences with getting the care their child needed and communicating with their child's personal doctor as the scores for the *Getting Needed Care* and *How Well Doctors Communicate* measures were statistically significantly higher than the 2021 NCQA CCC Medicaid national averages. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Adult members had less positive overall experiences with two of the three Effectiveness of Care measures, *Discussing Cessation Medications* and *Discussing Cessation Strategies*, as the scores for these measures were statistically significantly lower than the 2021 NCQA adult Medicaid national averages. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicated that Amerigroup providers may not be discussing cessation medications and strategies as much as other providers.

Recommendation: HSAG recommends that Amerigroup focus on initiatives through the MCO's QI program to provide medical assistance with smoking and tobacco use cessation and to develop efforts to promote a health education and wellness smoking cessation program.

Scorecard

The 2022 Iowa Managed Care Program MCO Scorecard was designed to compare MCO-to-MCO performance using HEDIS and CAHPS measure indicators. As such, MCO-specific results are not included in this section. Refer to the Scorecard activity in Section 7—MCP Comparative Information to review the 2021 Iowa Health Link MCO Scorecard, which is inclusive of Amerigroup's performance.

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

HSAG performed a comprehensive assessment of Amerigroup's aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within Amerigroup that impacted, or will have the likelihood to impact, member health outcomes.

HSAG also considered how Amerigroup's overall performance contributed to the Iowa Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 3-27 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to Amerigroup Medicaid members.

Table 3-27—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Care	**Quality**, **Timeliness**, and **Access**—Through HEDIS reporting, over the past three years, Amerigroup's rates for the *Access to Preventive Care* domain have shown a continual decrease for all seven measures. Further, one of the seven measure rates fell below the 25th percentile (*Use of Imaging Studies for Low Back Pain*), and three rates (*BMI Percentile Documentation–Total*, *Counseling for Nutrition–Total*, and *Counseling for Physical Activity–Total*) ranked at or above the 25th percentile but below the 50th percentile. Amerigroup's HEDIS rates had mixed results within the *Medication Management* domain. Specifically, 12 of the 18 measures rates demonstrated strong performance, suggesting that both child and adult members are accessing care, or their providers have been effectively treating members' conditions through appropriate medication management. However, five of the remaining six measure rates were at or above the 25th percentile but below the 50th percentile, and one rate was below the 25th percentile. Amerigroup also demonstrated mixed performance in the *Keeping Kids Healthy* domain. Four of the eight rates ranked at or above the 50th percentile but below the 75th percentile, two of the eight rates ranked at or above the 75th percentile but below the 90th percentile, while two of the eight rates ranked at or above the 25th percentile but below the 50th percentile. Accessing preventive care decreases the risk for diseases, disabilities, and death. Children also need regular preventive care visits to monitor their development and detect health problems early so they are easier to treat. However, Amerigroup demonstrated strong performance related to primary care through the compliance review, NAV, and CAHPS activities. Through the compliance review activity, Amerigroup demonstrated strong practices for ensuring providers are aware of its adopted practice guidelines, including guidelines that address acute and chronic conditions. Additionally, Amerigroup adhered to the network adequacy time/distance standards, indicating that members have access to PCPs and pediatricians within a reasonable time/distance from their residences. Amerigroup's adult members and parents/guardians of child members also reported good experiences in getting needed care in a timely manner as reported through CAHPS. Further, members appear to have been accessing timely services to obtain the preventive and/or condition-specific care they needed to maintain optimal health, as indicated in better HEDIS rates in the *Living With Illness* domain. Specifically, seven of the eight rates were at or above the 50th percentile, with one of those rates at or above the 75th percentile, and two of those rates at or above the 90th percentile.

Performance Area	Overall Performance Impact
Behavioral Health	**Quality, Timeliness,** and **Access**—Amerigroup's HEDIS measure rates for follow-up after an ED visit for AOD abuse or dependence within seven and 30 days were at or above the national Medicaid 90th percentile, demonstrating that Amerigroup has implemented policies, procedures, and processes to ensure members receive appropriate follow-up services after an ED visit for AOD abuse or dependence. Likewise, Amerigroup achieved rates for the *Follow-Up After ED Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness* measures that were at or above the 90th percentile, also demonstrating that Amerigroup has implemented policies, procedures, and processes to ensure members receive appropriate follow-up services after an ED visit or hospitalization for mental illness. Additionally, through the NAV activity, Amerigroup met the time/distance standards for both inpatient and outpatient behavioral health providers indicating Amerigroup has an adequate provider network to treat members with behavioral health conditions. However, the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* HEDIS measure rates indicated there are opportunities for Amerigroup to implement interventions to address medication management for members with related behavioral conditions.
Women's Health	**Quality, Timeliness,** and **Access**—Amerigroup's *Women's Health* domain measure rates indicated that members are not receiving recommended health screenings, as the rates for *Breast Cancer Screening*, *Cervical Cancer Screening,* and *Chlamydia Screening in Women* demonstrated a three-year downward trend, including the chlamydia screening rate being below the 25th percentile. Additionally, the *Timeliness of Prenatal Care* rate ranked at or above the 25th percentile but below the 50th percentile. However, for the *Timeliness of Postpartum Care* PIP, Amerigroup demonstrated statistically significant improvement from the baseline rate (68.9 percent) to the Remeasurement 1 rate (76.9 percent), indicating that women who delivered a live birth had a postpartum care visit on or between seven and 84 days after delivery, and that interventions implemented by Amerigroup had a positive impact for the study population. Further, for the HEDIS *Postpartum Care* measure, Amerigroup has shown a steady increase in the measure rate during the last three measurement years for postpartum women who are accessing postpartum care. Amerigroup has implemented strategies and processes to impact the HEDIS *Postpartum Care* measure, such as developing and implementing an educational webinar on prenatal and postpartum care for providers and clinical staff, providing educational resources to providers related to Current Procedural Terminology (CPT) coding, expanding live telephonic member outreach to provide education on the importance of prenatal and postpartum care, and assisting members with scheduling postpartum visits. Continuance of these interventions should support continued improvement in overall outcomes for pregnant women and their babies.

Performance Area	Overall Performance Impact
Person-Centered Care Planning for LTSS Members	**Quality, Timeliness,** and **Access**—Through the PMV activity, of the six reportable performance measures, Amerigroup's performance improved for the *Provision of Care Plan*, *Person-Centered Care Plan Meeting*, *Care Team Lead Chosen by Member*, and *Member Choice of HCBS Settings* measures in CY 2022 in comparison to CY 2021. Amerigroup implemented primary interventions aimed at improving the measure rates, which included identifying updates to the PCSP template for IHH members, using a follow-up reminder task to improve distribution of the care plan to members, and focusing on the performance measures during monthly auditing in the LTSS department. The impact of these interventions and Amerigroup's adherence to these expectations will be further assessed through future compliance reviews and specifically through the care coordination program area.
Disparities in Care	**Quality** and **Access**—Through the NAV activity, no variances were identified for the time/distance standard by member urbanicity, race/ethnicity, age, or living in an area of concentrated disadvantage, indicating that all Amerigroup members have equal access to providers and that there are currently no disparate groups. Amerigroup, as part of its targeted efforts to improve HEDIS rates, set a goal to improve the preterm birthrates among African American women. Amerigroup used analysis to determine that, for Iowans, the preterm birth rate among African American women was 32 percent higher than among all other women with different races/ethnicities. To address the identified disparity, Amerigroup chose to implement primary initiatives such as leveraging an OB practice consultant to increase provider collaboration, offering provider education, increasing referrals to case management and case management engagement, and initiating a doula program specific to African American pregnant women in Iowa. Additionally, as part of Amerigroup's QAPI program, and as a recipient of the NCQA Distinction in Multicultural Healthcare, Amerigroup evaluates efforts to improve the provision of CLAS and to identify and reduce care deficiencies related to CLAS and health disparities that provide a framework to deliver services that are culturally and linguistically appropriate and respectful, and that respond to members' cultural health beliefs, preferences, and communication needs. Through these initiatives, Amerigroup should effectively reduce disparities in care.
Member Satisfaction	**Quality**—Through the 2022 CAHPS activity, Amerigroup achieved scores that were statistically significantly higher than the 2021 national average in several categories for both adult and child surveys. Further, Amerigroup's CAHPS Measure—*Customer Service at Child's Health Plan Gave Information or Help Needed* PIP improved from the baseline rate of 84.3 percent to 92.9 percent for Remeasurement 1. The PIP interventions implemented by Amerigroup appear to have contributed to the increase in positive experiences reported by members completing the survey. However, through the compliance review activity, HSAG identified that Amerigroup was not consistently or fully resolving member grievances which could lead to member dissatisfaction with the MCO. Amerigroup was required to develop a CAP to remediate the identified deficiencies which should support improvement in the grievance process.

Iowa Total Care, Inc.

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of Iowa Total Care's PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-28 displays the overall validation status and the baseline and Remeasurement 1 results for each PIP topic.

Table 3-28—Overall Validation Rating for ITC

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
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.	72.5%	76.4% ⇔	
CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	*Met*	CAHPS Measure: Customer Service at Child's Health Plan gave help or information needed.	91%	94.4% ⇔	

R1 = Remeasurement 1
R2 = Remeasurement 2
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).

The goal for both PIPs is to demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-29 displays the interventions initiated by the MCO to support achievement of the PIP goal and address the barriers identified through QI and causal/barrier analysis process for each PIP topic.

Table 3-29—Remeasurement 1 Interventions for ITC

Intervention Descriptions	
Timeliness of Postpartum Care	***CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed***
Members were notified by phone of an available incentive. My Health Pays postpartum reward given to all postnatal members who completed a postpartum appointment on or between 7 and 84 days after delivery.	Updated internal employee communication methods to ensure timely dissemination of program materials.

Intervention Descriptions	
Timeliness of Postpartum Care	***CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed***
Automated text messages were sent to members who do not have a notification of pregnancy (NOP) assessment on file with the MCO but who may be pregnant based on claims data. These members were outreached to for enrollment in the MCO's Start Smart for Baby (SSFB) program.	Developed a guide to support front-line agents in answering common pharmacy questions from members with a method for direct routing of questions to the pharmacy team.
Shared reports with providers of members who may be pregnant based on claims data but without an NOP on file. Providers were encouraged to submit NOPs to the MCO to help identify pregnant members earlier in pregnancy and for enrollment in the SSFB program.	Utilized after-call surveys and quality checks to ensure agents are performing as expected.
Members were encouraged to complete an NOP to secure a free breast pump. Filling out an NOP to secure a breast pump provided opportunities for member outreach by the SSFB team.	

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Iowa Total Care used appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement within its current processes. [**Quality**]

Strength #2: Iowa Total Care achieved programmatically significant improvement over the baseline performance for both PIP topics. For the *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed* PIP, the MCO implemented after-call surveys and quality checks to ensure member services agents were performing as expected. The average score for the member services department increased by 2 percent from 2020 to 2021. Additionally, for the *Timeliness of Postpartum Care* PIP, provider education and member outreach increased the number of pregnancy notifications received by the MCO from 2020 to 2021. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for Iowa Total Care through the PIP activity.

Why the weakness exists: NA

Recommendation: NA

Performance Measure Validation

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. Additionally, Iowa Total Care was able to answer HSAG's questions, and HSAG did not identify any issues during the PSV interview session, which included a focus on member-specific enrollment, claims, and case management data to support performance measures #1, 2, 3, 4, 5, and 6.

Table 3-30, Table 3-31, Table 3-32, and Table 3-33 display measure designation and reportable measure rates for SFY 2022. 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 3-30—SFY 2022 #1a Performance Measure Designation and Rates for ITC*

Performance Measure		Measure Designation	Measure Rate				
			0%	1–49%	50–74%	75–89%	90–100%
1a	*Percentage of Eligible Members With Applicable Percentage of Authorized Services Utilized*	*R*	3.60%	36.66%	20.40%	13.65%	25.69%

* Rates are provided for information only.

Table 3-31—SFY 2022 #1b Performance Measure Designation and Rates for ITC*

Performance Measure		Measure Designation	Measure Rate
1b	*The Percentage of Eligible Members for Whom 100 Percent of HCBS Documented in Members' Care Plans Had a Corresponding Approved Service Authorization*	*R*	92.87%

* Rates are provided for information only.

Table 3-32—SFY 2022 #2 Performance Measure Designation and Rates for ITC*

Performance Measure		Measure Designation	Measure Results		
			Denominator	Numerator	Rate
2a	*Members With One or More Documented Care Plan One-Time Service*	*R*	1,304	7	0.54%

Performance Measure		Measure Designation	Measure Results		
			Denominator	Numerator	Rate
2b	*Members With Documented Care Plan One-Time Service With Corresponding Approved Service Authorization*	*R*	7	6	85.71%
2c	*Percentage of Authorized One-Time Services Utilized*	*R*	6	4	66.67%

* Rates are provided for information only.

Table 3-33—SFY 2022 #3, #4, #5, and #6 Performance Measure Designation and Rates for ITC

Performance Measure		Measure Designation	Measure Results		
			Denominator	Numerator	Rate
3	*Provision of Care Plan*	*R*	1,229	1,161	94.47%
4	*Person-Centered Care Plan Meeting**	*R*	1,229	1,196	97.31%
5	*Care Team Lead Chosen by the Member*	*R*	1,229	1,224	99.59%
6	*Member Choice of HCBS Settings*	*R*	1,229	1,214	98.78%

* 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

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

Strengths

Strength #1: Iowa Total Care continued to use an agile approach to ensuring the health and safety of its LTSS members throughout the COVID-19 PHE. It authorized duplicate services so that preferred services that were experiencing limitations could be accessed easily when they became available. Iowa Total Care also closely monitored utilization for adjustments that were needed due to limited service availability and/or staffing issues in certain areas. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Iowa Total Care's performance improved on measures 3 through 6 in SFY 2022 in comparison to SFY 2021. Iowa Total Care used TruCare data extracts to continuously monitor performance and address deficiencies throughout the measurement year. For example, the CBCM Snapshot report provided a status on all LTSS members on measures 3 through 6. LTSS leadership

worked closely with the CBCMs to monitor members who were not compliant on the measures and to improve documentation processes to ensure an accurate picture of performance. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Iowa Total Care had not yet completed the integration of the PCSP in TruCare and was relying on the member reporting assessment (MRA) in TruCare to capture the data required for the performance measures while using Microsoft Word to document full PCSPs that were uploaded into TruCare. [**Quality**]

Why the weakness exists: Iowa Total Care began integrating a PCSP version with reportable fields for all data documented in the service plan in 2019, but Iowa Total Care identified issues during the testing process when meeting with members in the field. Iowa Total Care has been working with its IT team to deploy fixes to the PCSP form in TruCare and to test an updated version with the Iowa Total Care LTSS staff members.

Recommendation: HSAG recommends that Iowa Total Care prioritize the deployment of the reportable PCSP in TruCare to continue expanding its reporting and monitoring capabilities and reduce administrative burden on LTSS staff members.

Weakness #2: Iowa Total Care used a manual process to integrate Access2Care waiver transportation encounter data derived from a spreadsheet with the other LTSS claims data extracted for measure 1. [**Quality**]

Why the weakness exists: Iowa Total Care had not yet completed migration of Access2Care waiver transportation encounter data into its data warehouse.

Recommendation: Iowa Total Care is encouraged to prioritize the migration of vendor encounters for waiver transportation into its data warehouse to reduce the potential for error associated with manual data integration.

Performance Results—HEDIS

HSAG's review of the FAR for HEDIS MY 2021 showed that Iowa Total Care's HEDIS compliance auditor found Iowa Total Care's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. Iowa Total Care contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

Table 3-34—HEDIS MY 2021 Results for ITC

Measures	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Three-Year Trend	Star Rating
Access to Preventive Care					
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	—	77.47%	78.84%	—	★★★

Measures	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Three-Year Trend	Star Rating
45–64 Years	—	85.78%	85.56%	—	★★★
65 Years and Older	—	81.78%	85.80%	—	★★★
Use of Imaging Studies for Low Back Pain					
Use of Imaging Studies for Low Back Pain	—	69.46%	68.70%	—	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile Documentation—Total	—	69.83%	72.02%	—	★★
Counseling for Nutrition—Total	—	61.56%	61.80%	—	★★
Counseling for Physical Activity—Total	—	55.72%	58.15%	—	★★
Women's Health					
Breast Cancer Screening					
Breast Cancer Screening	—	NA	44.82%	—	★
Cervical Cancer Screening					
Cervical Cancer Screening	—	49.64%	55.72%	—	★★
Chlamydia Screening in Women					
Total	—	45.61%	48.67%	—	★★
Non-Recommended Cervical Cancer Screening in Adolescent Females*					
Non-Recommended Cervical Cancer Screening in Adolescent Females	—	0.61%	0.50%	—	★★★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	—	69.59%	75.43%	—	★
Postpartum Care	—	72.51%	76.40%	—	★★★
Living With Illness					
Comprehensive Diabetes Care					
HbA1c Testing	—	85.64%	91.24%	—	★★★★★
HbA1c Control (<8.0%)	—	38.93%	52.31%	—	★★★★
*HbA1c Poor Control (>9.0%)**	—	50.12%	39.90%	—	★★★
Blood Pressure Control (<140/90 mm Hg)	—	65.21%	69.34%	—	★★★★
Eye Exam (Retinal) Performed	—	51.82%	59.37%	—	★★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	62.53%	67.88%	—	★★★★★
Statin Therapy for Patients With Cardiovascular Disease					
Received Statin Therapy—Total	—	NA	62.03%	—	★

Measures	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Three-Year Trend	Star Rating
Statin Therapy for Patients With Diabetes					
Received Statin Therapy	—	NA	50.19%	—	★
Behavioral Health					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	—	43.47%	55.15%	—	★
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	—	73.54%	77.13%	—	★★★
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence					
7 Day Follow-Up—Total	—	44.17%	48.63%	—	★★★★★
30 Day Follow-Up—Total	—	50.95%	54.68%	—	★★★★★
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—Total	—	61.36%	60.85%	—	★★★★
30-Day Follow-Up—Total	—	72.48%	72.37%	—	★★★★
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	—	30.72%	45.06%	—	★★★
30-Day Follow-Up—Total	—	50.94%	66.00%	—	★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment					
Initiation of AOD Treatment—Total	—	76.18%	47.26%	—	★★★
Engagement of AOD Treatment—Total	—	28.41%	16.87%	—	★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose and Cholesterol Testing–Total	—	20.76%	23.35%	—	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	—	59.16%	64.48%	—	★★★
Keeping Kids Healthy					
Childhood Immunization Status					
Combination 3	—	70.07%	71.05%	—	★★★

Measures	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Three-Year Trend	Star Rating
Combination 10	—	41.36%	44.04%	—	★★★
Immunizations for Adolescents					
Combination 1	—	84.18%	85.64%	—	★★★
Combination 2	—	28.71%	34.06%	—	★★
Lead Screening in Children					
Lead Screening in Children	—	77.62%	74.81%	—	★★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	34.58%	51.47%	—	★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	60.51%	55.82%	—	★
Child and Adolescent Well-Care Visits					
Total	—	38.02%	42.20%	—	★★
Medication Management					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	—	60.76%	60.38%	—	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	55.31%	58.98%	—	★★★
Effective Continuation Phase Treatment	—	40.78%	42.07%	—	★★★
Appropriate Testing for Pharyngitis					
Total	—	80.22%	77.53%	—	★★★
Appropriate Treatment for Upper Respiratory Infection					
Total	—	86.54%	90.99%	—	★★★
Asthma Medication Ratio					
Total	—	NA	68.37%	—	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Total	—	51.14%	51.10%	—	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	—	54.49%	42.28%	—	★★
Continuation and Maintenance Phase	—	61.19%	50.11%	—	★★

Measures	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Three-Year Trend	Star Rating
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	—	67.78%	73.91%	—	★
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	—	42.43%	58.32%	—	★
Bronchodilator	—	49.03%	67.19%	—	★
Statin Therapy for Patients With Cardiovascular Disease					
Statin Adherence 80%—Total	—	NA	67.32%	—	★★
Statin Therapy for Patients With Diabetes					
Statin Adherence 80%—Total	—	NA	65.87%	—	★★
Use of Opioids at High Dosage*					
Use of Opioids at High Dosage	—	2.25%	1.72%	—	★★★★
Use of Opioids From Multiple Providers*					
Multiple Prescribers	—	15.87%	17.39%	—	★★★
Multiple Pharmacies	—	1.64%	1.63%	—	★★★★
Multiple Prescribers and Multiple Pharmacies	—	1.22%	1.20%	—	★★★

* For this indicator, a lower rate indicates better performance.

— Indicates that the rate is not presented because the MCO was not required to report the measure until MY 2020. This symbol may also indicate that NCQA recommended a break in trending; therefore, the rate is not displayed.

HEDIS MY 2021 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 2022

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

Strengths

Strength #1: Iowa Total Care's performance under the Living With Illness domain improved notably this year across all indicators for the *Comprehensive Diabetes Care* measure. The *Comprehensive Diabetes Care–HbA1c Poor Control (>9.0%)* improved from below the 25th percentile to at or above the 50th percentile; the *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed* indicators improved from below the 25th percentile to at or above the 75th percentile, while the *Comprehensive Diabetes Care—HbA1c Testing* indicator improved from below the 25th percentile to at or above the 90th percentile. [**Quality**]

Strength #2: Iowa Total Care's performance in the Women's Health domain improved this year in several areas. The *Cervical Cancer Screening* and *Chlamydia Screening in Women* measures both improved from below the 25th percentile to at or above the 25th percentile. The *Prenatal and Postpartum Care—Postpartum Care* indicator improved from at or above the 25th percentile to at or above the 50th percentile. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: Iowa Total Care's performance under the Women's Health domain ranked below the 25th percentile for the *Breast Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicators, indicating that a large number of women were not being seen or screened by their providers. Breast cancer is the most common cancer among American women, regardless of race or ethnicity, and screening can improve outcomes. Additionally, timely and adequate prenatal care can promote the long-term health and wellbeing of new mothers and their infants. [**Quality**, **Timeliness** and **Access**]

Why the weakness exists: The low rates for *Breast Cancer Screening* suggest that barriers exist for women between 50 and 74 years of age to access these important health screenings, and the COVID-19 pandemic may have increased these barriers. Additionally, the low *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator rate suggests that women were experiencing barriers to timely access to providers for prenatal care.

Recommendation: HSAG recommends that Iowa Total Care partner with primary care and OB/GYN providers to determine why some females were not getting screened for breast cancer and should evaluate access to mammogram services in its network for females who were noncompliant for the measure. In addition, HSAG recommends that Iowa Total Care conduct further analysis to evaluate whether any particular age groups or racial/ethnic groups have a significantly different rate for accessing prenatal care. Upon identification of a root cause, Iowa Total Care should implement appropriate interventions (contracting efforts, member education, transportation assistance, specialized pregnancy supports such as doula services or certified health workers, etc.) to improve low performance rates within the Women's Health domain.

Weakness #2: Iowa Total Care's performance in the Behavioral Health domain continued to rank below the 25th percentile for *Diabetes Monitoring for People With Diabetes and Schizophrenia* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and*

Cholesterol Testing. These low rates indicate that patients receiving behavioral health treatment and using antipsychotic medication were not always being monitored properly. Addressing the physical health needs of members diagnosed with mental health conditions is an important way to improve overall health, quality of life, and economic outcomes. Additionally, monitoring of blood glucose and cholesterol testing are important components of ensuring appropriate management of children and adolescents on antipsychotic medications. [**Quality**]

Why the weakness exists: Low rates suggest that there are barriers to appropriate monitoring for adults and children with severe and persistent mental illness who are being treated with psychotropic medication, potentially with behavioral health providers not ordering the correct tests for monitoring.

Recommendation: HSAG recommends that Iowa Total Care continue to partner with providers to determine why some members with severe mental illnesses are not being monitored for diabetes or for metabolic functioning, such as by providing education and assistance when needed to ensure behavioral health providers understand which tests to monitor and how to access lab testing. Iowa Total Care should continue to work with providers to implement appropriate interventions (e.g., process improvements, patient education campaign, and provider incentives) to improve the performance rates of these measures.

Compliance Review

Performance Results

Table 3-35 presents Iowa Total Care's compliance scores for each standard evaluated during the current three-year compliance review cycle. Iowa Total Care was required to submit a CAP for all standards scoring less than 100 percent compliant. Iowa Total Care's implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-35—Standard Compliance Scores for ITC

Compliance Review Standards	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (CY 2021)		
Standard I—Disenrollment: Requirements and Limitations	§438.56	**71%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**90%**
Standard III—Emergency and Poststabilization Services	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**89%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**

Compliance Review Standards	Associated Federal Citations[1]	Compliance Score
Standard VI—Coordination and Continuity of Care	§438.208	**100%**
Standard VII—Coverage and Authorization of Services	§438.210	**80%**
Year Two (CY 2022)		
Standard VIII—Provider Selection	§438.214	**86%**
Standard IX—Confidentiality	§438.224	**100%**
Standard X—Grievance and Appeal Systems	§438.228	**89%**
Standard XI—Subcontractual Relationships and Delegation	§438.230	**100%**
Standard XII—Practice Guidelines	§438.236	**100%**
Standard XIII—Health Information Systems[2]	§438.242	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	**97%**
Year Three (CY 2023)		
Review of MCO implementation of Year One and Year Two CAPs		

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

[2] The Health Information Systems standard includes an assessment of the MCO's IS capabilities.

Table 3-36 presents Iowa Total Care's scores for each standard evaluated during the CY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in Iowa Total Care's written documents, including policies, procedures, reports, and meeting minutes; and interviews with MCO staff members. The CY 2022 Compliance Review activity demonstrated how successful Iowa Total Care was in interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with HHS.

Table 3-36—CY 2022 Standard Compliance Scores for ITC

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	14	14	12	2	0	**86%**
Standard IX—Confidentiality	12	12	12	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	34	4	0	**89%**
Standard XI—Subcontractual Relationships and Delegation	13	13	13	0	0	**100%**
Standard XII—Practice Guidelines	6	6	6	0	0	**100%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard XIII—Health Information Systems	9	9	9	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	30	30	29	1	0	**97%**
Total	**122**	**122**	**115**	**7**	**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.
[1] The Health Information Systems standard included an assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Iowa Total Care achieved full compliance for the Confidentiality program area, demonstrating that the MCO had appropriate policies and processes for the use and disclosure of members' protected health information (PHI) and members' privacy rights, and provided required notices related to privacy practices. [**Quality**]

Strength #2: Iowa Total Care achieved full compliance for the Subcontractual Relationships and Delegation program area, demonstrating that the MCO had appropriate subcontracts in place and had adequate oversight and monitoring processes to ensure its delegates were meeting their contractual obligations. [**Quality**]

Strength #3: Iowa Total Care achieved full compliance for the Practice Guidelines program area, demonstrating that the MCO adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines. [**Quality** and **Access**]

Strength #4: Iowa Total Care achieved full compliance for the Health Information Systems program area, demonstrating that the MCO maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for Iowa Total Care as no program area scored at or below 80 percent compliance.

Why the weakness exists: NA

Recommendation: NA

Network Adequacy Validation

Performance Results

Table 3-37 illustrates the number of unique providers in the Iowa Total Care Medicaid network (enrolled as of July 31, 2022), as well as provider-to-member ratios for adult and pediatric member populations across primary and behavioral healthcare. Table 3-38 demonstrates that 100 percent of adult and pediatric members had access to PCPs within the time/distance standard. Table 3-39 demonstrates the percentage of adult and pediatric members who had access to behavioral health providers within the time/distance standard for Iowa Total Care.

Table 3-37—Provider Capacity Analysis for Medicaid and Hawki Members for Iowa Total Care

Provider Category	Medicaid		Hawki	
	Number of Unique Providers	Provider-to-Member Ratio	Number of Unique Providers	Provider-to-Member Ratio
Primary Care Provider				
Primary Care Provider—Adult	3,856	1:50	NA	NA
Primary Care Provider—Pediatric	3,420	1:40	3,420	1:5
Behavioral Health Provider				
Behavioral Health Provider, Inpatient	91	1:3,593	91	1:165
Behavioral Health Provider, Outpatient	3,602	1:91	3,602	1:5

NA: Not applicable

Table 3-38—Percentage of Members With Access to PCPs Within Time/Distance Standards for Iowa Total Care

Percentage of Members With Access to Primary Care Providers Within the Time/Distance Standards (30 miles or 30 minutes)			
Stratification	**Adult Members**	**Pediatric Members**	
	Medicaid	**Medicaid**	**Hawki**
Urbanicity			
Urban	100.0%	100.0%	100.0%
Rural	100.0%	100.0%	100.0%
Concentrated Disadvantage Index			
No	100.0%	100.0%	100.0%
Yes	100.0%	100.0%	100.0%
Age Category			
18 and Under	NA	100.0%	100.0%
19 to 64 years	100.0%	NA	NA
65 and Older	100.0%	NA	NA
Race/Ethnicity			
American Indian or Alaska Native	100.0%	100.0%	100.0%
Asian	100.0%	100.0%	100.0%
Black or African American	100.0%	100.0%	100.0%
*Hispanic**	100.0%	100.0%	100.0%
Two or More Races	100.0%	100.0%	100.0%
Native Hawaiian and Other Pacific Islander	100.0%	100.0%	100.0%
Unknown	100.0%	100.0%	100.0%
White	100.0%	100.0%	100.0%
Overall			
Overall	100.0%	100.0%	100.0%

NA: Not applicable
*Those identified as Hispanic can be of any race or combination of races. All other categories with the exception of Unknown are non-Hispanic.

Table 3-39—Percentage of Members With Access to Behavioral Health Providers Within Time/Distance Standards for Iowa Total Care

Percentage of Members With Access to Behavioral Health Providers Within the Time/Distance Standards				
Stratification	Inpatient BH Providers		Outpatient BH Providers	
	Medicaid	Hawki	Medicaid	Hawki
Urbanicity				
Urban	100.0%	100.0%	>99.9%	>99.9%
Rural	100.0%	100.0%	99.6%	99.5%
Concentrated Disadvantage Index				
No	100.0%	100.0%	99.7%	99.6%
Yes	100.0%	100.0%	>99.9%	99.9%
Age Category				
18 and Under	100.0%	100.0%	99.8%	99.7%
19 to 64 years	100.0%	NA	99.8%	NA
65 and Older	100.0%	NA	99.7%	NA
Race				
American Indian or Alaska Native	100.0%	100.0%	99.5%	98.0%
Asian	100.0%	100.0%	>99.9%	100.0%
Black or African American	100.0%	100.0%	>99.9%	100.0%
*Hispanic**	100.0%	100.0%	>99.9%	100.0%
Two or More Races	100.0%	100.0%	99.9%	99.3%
Native Hawaiian and Other Pacific Islander	100.0%	100.0%	>99.9%	100.0%
Unknown	100.0%	100.0%	99.8%	99.8%
White	100.0%	100.0%	99.8%	99.7%
Overall				
Overall	100.0%	100.0%	99.8%	99.7%

NA: Not applicable
*Those identified as Hispanic can be of any race or combination of races. All other categories except Unknown are non-Hispanic.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Iowa Total Care met all time/distance requirements for primary care and inpatient behavioral health providers. The access to providers did not vary by member urbanicity, race/ethnicity, age, or living in an area of concentrated disadvantage. [**Timeliness** and **Access**]

Strength #2: While less than 1 percent of Iowa Total Care members did not have access to outpatient behavioral health providers within the time/distance standards, variations by member urbanicity, race/ethnicity, age, or living in an area of concentrated disadvantage were not substantial. [**Timeliness** and **Access**]

Weaknesses and Recommendations

Weakness #1: Less than 1 percent of Iowa Total Care members did not have access to outpatient behavioral health providers within the time/distance standards. [**Timeliness** and **Access**]

Why the weakness exists: The number of members without access to outpatient behavioral health providers within the time/distance standards is small, but likely exists because much of Iowa is rural. The health plan may struggle to contract with providers to ensure that members in very rural areas or on the outskirts of urban areas can access providers withing 30 miles or 30 minutes.

Recommendation: Since the percentage of members with access is very high, HSAG recommends that Iowa Total Care continue to monitor the provider network to ensure the percentage of members with access to outpatient behavioral health providers does not decrease and consider contracting with additional providers as available.

Encounter Data Validation

Performance Results—Medical Record Review

Table 3-40 presents the percentage of medical record documentation submissions, and Table 3-41 presents the major reasons medical record documentation was not submitted by Iowa Total Care.

Table 3-40—Summary of Medical Records Requested and Received for ITC

MCO	Number of Records Requested	Records Submitted		Records Submitted With Second Date of Service	
		Number	Percent[1]	Number	Percent[2]
Iowa Total Care	411	389	94.6%	368	94.6%

[1] Percent was calculated based on number of records requested and number of records submitted.
[2] Percent was calculated based on number of records submitted and number of records submitted with second date of service.

Table 3-41—Reasons Medical Records Not Submitted for Date of Service for ITC

Reason	Number	Percent
Record not located at this facility; location unknown	0	0.0%
Member is a patient of the practice; however, no documentation was available for requested dates of service	4	18.2%
Member is not a patient of this practice	0	0.0%
Non-responsive provider or provider did not respond in a timely manner	18	81.8%
Provider refused to release record	0	0.0%
Facility is permanently closed; unable to procure record	0	0.0%
Other	0	0.0%
Total*	**22**	**100.0%**

*The sum of the percentages of all non-submission reasons may not equal 100 percent due to rounding.

Table 3-42 displays the medical record omission, encounter data omission, element accuracy, and all-element accuracy rates for each key data element.

Table 3-42—Encounter Data Completeness and Accuracy Summary for ITC

Key Data Element	Medical Record Omission[1]	Encounter Data Omission[2]	Element Accuracy[3]	Inaccuracy Reasons
Date of Service	4.5%	1.3%	—	—

Key Data Element	Medical Record Omission[1]	Encounter Data Omission[2]	Element Accuracy[3]	Inaccuracy Reasons
Diagnosis Code	7.4%	0.7%	99.8%	1. Inaccurate Code (66.7%) 2. Specificity Error (33.3%)
Procedure Code	12.2%	3.0%	97.9%	1. Inaccurate Code (100.0%) 2. Higher Level of Service in Medical Record (0.0%) 3. Lower Level of Service in Medical Record (0.0%)
Procedure Code Modifier	15.7%	6.2%	99.3%	—
All-Element Accuracy[4]	—	—	78.2%	—

"—" Denotes that the error type analysis was not applicable to a given data element.

[1] Services documented in the encounter data but not supported by the members' medical records. Lower rate values indicate better performance.

[2] Services documented in the members' medical records but not in the encounter data. Lower rate values indicate better performance.

[3] Services documented in the members' medical records associated with validated dates of service from the encounter data that were correctly coded based on the medical records. Higher rate values indicate better performance.

[4] The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate from each data element.

Strengths, Weaknesses, and Recommendations—Medical Record Review

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

Strengths

Strength #1: The dates of service, diagnosis codes, and procedure codes identified in the members' medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 1.3 percent, 0.7 percent, and 3.0 percent, respectively.

Strength #2: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate, each with rates of at least 97.0 percent.

Weaknesses and Recommendations

Weakness #1: Iowa Total Care was unable to procure all requested medical records from its contracted providers due to providers being non-responsive or not responding in a timely manner, or documentation being unavailable for the requested dates of service.

Why the weakness exists: The non-submission reason for non-responsive providers or providers who did not respond in a timely manner may indicate that the contracted providers were unaware of the submission requirements or the deadline. The non-submission reason for not having documentation available for the requested dates of service may indicate inconsistencies between the information stored in the provider's office versus HHS' encounter data or that an encounter was submitted to HHS even though a member did not access care.

Recommendation: Iowa Total Care should ensure its contracted providers' accountability in responding to medical record requests for auditing, inspection, and oversight. HSAG recommends that Iowa Total Care consider strengthening and/or enforcing contract requirements with its providers in supplying the requested documentation. For the non-submission reason for not having documentation available, Iowa Total Care should investigate and follow up with its providers to determine why encounters were submitted to HHS but no documentation/medical records were available for the requested dates of service. Based on the findings, Iowa Total Care should consider taking additional action, as appropriate (e.g., request overpayment of funds).

Weakness #2: The medical record omission rates (i.e., data elements in the encounter data were not supported by members' medical records) were high for the *Procedure Code* and *Procedure Code Modifier* data elements, each with rates greater than 10.0 percent.

Why the weakness exists: Factors contributing to data elements not being supported by the members' medical records may have been due to providers not documenting the services in the medical records despite submitting a claim or encounter.

Recommendation: Iowa Total Care should consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews would then be shared with providers through periodic education and training regarding data submissions, medical record documentation, and coding practices.

Performance Results—Comparative Analysis

There are two aspects of record completeness—record omission and record surplus. Table 3-43 displays the percentage of records present in the files submitted by Iowa Total Care that were not found in the HHS-submitted files (record omission), and the percentage of records present in the HHS-submitted files but not present in Iowa Total Care-submitted files (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 3-43—Record Omission and Surplus Rates for ITC

Encounter Type	Record Omission	Record Surplus
Professional	7.7%	4.5%

Encounter Type	Record Omission	Record Surplus
Institutional	19.7%[1]	<0.1%
Pharmacy	0.4%	<0.1%

[1] Iowa Total Care confirmed that the Iowa Total Care-submitted data included the appropriate records as requested.

Table 3-44 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the professional encounters for Iowa Total Care. For the element omission and surplus indicators, lower rates indicate better performance, whereas for the element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, neither lower nor higher rates indicate better or worse performance.

Table 3-44—Data Element Omission, Surplus, Absent, and Accuracy: Professional Encounters for ITC

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Member ID	0.0%	0.0%	0.0%	>99.9%
Detail Service From Date	0.0%	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	0.0%	>99.9%
Billing Provider NPI	0.0%	3.6%	<0.1%	99.7%
Rendering Provider NPI[2]	0.0%	41.4%	<0.1%	100.0%
Referring Provider NPI[1]	2.1%	0.0%	57.7%	>99.9%
Primary Diagnosis Code	0.0%	0.0%	0.0%	92.8%
Secondary Diagnosis Code[1]	0.0%	11.6%	51.3%	92.6%
CDT/CPT/HCPCS Procedure Code	0.0%	<0.1%	0.0%	>99.9%
Procedure Code Modifier[1]	<0.1%	<0.1%	56.1%	>99.9%
Units of Service	0.0%	0.0%	0.0%	99.6%
NDC[1]	<0.1%	0.0%	93.5%	100.0%
Detail Paid Amount	0.0%	0.0%	0.0%	99.7%

* NPI = National Provider Identifier; CDT = Current Dental Terminology; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code

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

[2] HHS had noted that if *Rendering Provider NPI* values were submitted by the MCO in the encounter data, the Iowa MMIS captured the submitted values. However, if the *Rendering Provider NPI* values were not submitted, the MMIS populated the *Rendering Provider NPI* with the *Billing Provider NPI* values. As a result, when records were compared, the field values were present in the HHS-submitted data files while values were not present in the MCO-submitted data files (i.e., element surplus).

Table 3-45 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the institutional encounters for Iowa Total Care. 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, neither lower nor higher rates indicate better or worse performance.

Table 3-45—Data Element Omission, Surplus, Absent, and Accuracy: Institutional Encounters for ITC

Key Data Elements*	Element Omission	Element Surplus	Element Absent	Element Accuracy
Member ID	0.0%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	0.0%	>99.9%
Admission Date[1]	0.0%	<0.1%	76.1%	>99.9%
Billing Provider NPI	0.0%	<0.1%	0.0%	>99.9%
Attending Provider NPI	0.0%	0.0%	0.5%	100.0%
Referring Provider NPI[1]	<0.1%	0.1%	96.3%	100.0%
Primary Diagnosis Code	0.0%	0.0%	0.0%	>99.9%
Secondary Diagnosis Code[1]	<0.1%	<0.1%	16.2%	>99.9%
CDT/CPT/HCPCS Procedure Code[1]	0.1%	0.2%	17.9%	96.9%
Procedure Code Modifier[1]	0.5%	0.5%	75.5%	99.2%
Units of Service	0.0%	0.0%	0.0%	93.3%
Primary Surgical Procedure Code[1]	1.2%	0.0%	93.3%	100.0%
Secondary Surgical Procedure Code[1]	0.8%	0.0%	95.6%	99.8%
NDC[1]	0.5%	0.2%	89.4%	91.0%
Revenue Code	0.0%	0.0%	0.0%	98.2%
DRG Code[1]	0.0%	<0.1%	89.7%	99.9%
Header Paid Amount	0.0%	0.0%	0.0%	96.1%
Detail Paid Amount	0.0%	0.0%	0.0%	98.1%

* NPI = National Provider Identifier; CDT = Current Dental Terminology; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code; DRG = Diagnosis Related Group

[1] *Admission Date*, *Referring Provider NPI*, *Secondary Diagnosis Code*, *CDT/CPT/HCPCS 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 encounter transaction).

Table 3-46 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the pharmacy encounters for Iowa Total Care. 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, neither lower nor higher rates indicate better or worse performance.

Table 3-46—Data Element Omission, Surplus, Absent, and Accuracy: Pharmacy Encounters for ITC

Key Data Elements*	Element Omission	Element Surplus	Element Absent	Element Accuracy
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	0.0%	0.0%	0.0%	99.8%
Drug Quantity	0.1%	0.0%	0.0%	96.1%
Header Paid Amount	0.0%	0.0%	0.0%	100.0%
Dispensing Fee	0.0%	0.0%	0.0%	100.0%

* NPI = National Provider Identifier; NDC = National Drug Code

Table 3-47 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 Iowa Total Care. For the all-element accuracy indicator, higher rates indicate better performance.

Table 3-47—All-Element Accuracy and Encounter Type for ITC

Professional Encounters	Institutional Encounters	Pharmacy Encounters
79.3%	87.7%	95.7%

Strengths, Weaknesses, and Recommendations—Comparative Analysis

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

Strengths

Strength #1: The record surplus rates for professional and institutional encounters were low at less than 5.0 percent, suggesting that encounters in HHS-submitted data were corroborated in the Iowa Total Care data. Additionally, the pharmacy encounters exhibited complete data with low record omission and record surplus rates.

Strength #2: Among encounters that could be matched between data extracted from the HHS data warehouse and data extracted from Iowa Total Care's data system, a high level of completeness (i.e., low element omission and surplus rates) was exhibited, with few exceptions.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for Iowa Total Care through the EDV activity.

Why the weakness exists: NA

Recommendation: NA

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-48 presents Iowa Total Care's 2022 adult Medicaid and general child Medicaid CAHPS top-box scores.[3-2] Arrows (↓ or ↑) indicate 2022 scores that were statistically significantly higher or lower than the 2021 national average.

Table 3-48—Summary of 2022 CAHPS Top-Box Scores for ITC

	2022 Adult Medicaid	2022 General Child Medicaid
Composite Measures		
Getting Needed Care	86.5%	86.1%
Getting Care Quickly	NA	89.9% ↑
How Well Doctors Communicate	92.2%	95.2%
Customer Service	NA	85.6%
Global Ratings		
Rating of All Health Care	61.4%	76.5% ↑
Rating of Personal Doctor	70.2%	81.1% ↑
Rating of Specialist Seen Most Often	NA	78.0%
Rating of Health Plan	60.3%	73.0%
Effectiveness of Care Measures*		
Advising Smokers and Tobacco Users to Quit	73.3%	
Discussing Cessation Medications	53.1%	
Discussing Cessation Strategies	47.2%	

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."

[3-2] ITC administered the CAHPS 5.1H Child Medicaid Health Plan Survey without the CCC measurement set; therefore, results for the CCC Medicaid population are not available and cannot be presented.

* These scores follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.
Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Parents/caretakers of child members in the general child population had positive experiences with getting care for their child quickly, their child's health care overall, and their child's personal doctor, as the scores for the *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Personal Doctor* measures were statistically significantly higher than the 2021 NCQA child Medicaid national averages. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any CAHPS survey weaknesses for Iowa Total Care.

Why the weakness exists: NA

Recommendation: While no weaknesses were identified, HSAG recommends that Iowa Total Care continue to monitor the measures to ensure there are no significant decreases in scores over time.

Scorecard

The 2022 Iowa Managed Care Program MCO Scorecard was designed to compare MCO-to-MCO performance using HEDIS and CAHPS measure indicators. As such, MCO-specific results are not included in this section. Refer to the Scorecard activity in Section 7—MCP Comparative Information to review the 2021 Iowa Health Link MCO Scorecard, which is inclusive of Iowa Total Care's performance.

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

HSAG performed a comprehensive assessment of Iowa Total Care's aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within Iowa Total Care that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how Iowa Total Care's overall performance contributed to the Iowa Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 3-49 displays

each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to Iowa Total Care Medicaid members.

Table 3-49—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Care	**Quality**, **Timeliness**, and **Access**—Through HEDIS reporting, overall, the *Access to Preventive Care*, *Medication Management*, and *Keeping Kids Healthy* domains had mixed results. Within the *Access to Preventive Care* domain, one of the seven rates was ranked below the 25th percentile (*Use of Imaging Studies for Low Back Pain*), and three rates (*BMI Percentile Documentation–Total*, *Counseling for Nutrition–Total*, and *Counseling for Physical Activity–Total*) ranked at or above the 25th percentile but below the 50th percentile. However, *Adults' Access to Preventive/Ambulatory Health Services* measure rates for all age bands were ranked at or above the 50th percentile but below the 75th percentile. Within the *Medication Management* domain, two measures ranked at or above the 75th percentile but below the 90th percentile, and seven measures ranked at or above the 50th percentile but below the 75th percentile. However, six measures ranked at or above the 25th percentile but below the 50th percentile, and three measures ranked below the 25th percentile, suggesting opportunities exist for both child and adult members to access care, or for their providers to effectively treat members' conditions through appropriate medication management. Further, four of the eight rates in the *Keeping Kids Healthy* domain were ranked at or above the 50th percentile but below the 75th percentile, while three measure rates ranked at or above the 25th percentile but below the 50th percentile. Accessing preventive care decreases the risk for diseases, disabilities, and death. Children also need regular preventive care visits to monitor their development and detect health problems early so they are easier to treat. However, Iowa Total Care demonstrated strong performance related to primary care through the compliance review, NAV, and CAHPS activities. Through the compliance review activity, Iowa Total Care demonstrated strong practices for ensuring providers are aware of its adopted practice guidelines, including guidelines that address acute and chronic conditions. Additionally, Iowa Total Care adhered to the network adequacy time/distance standards indicating members have access to PCPs and pediatricians within a reasonable time/distance from their residences. Through the CAHPS activity, one of the six composite measures had 2022 scores that were statistically significantly higher than the 2021 national average. Specifically, parents/guardians of children reported more positive experiences for the *Getting Care Quickly* composite measure. Further, as seen through HEDIS reporting, Iowa Total Care's members appear to have accessed services in a timely manner to obtain needed services to treat diabetes and hypertension, as indicated in better HEDIS rates in the *Living With Illness* domain. Specifically, six of the eight rates ranked at or above the 50th percentile, with three of those rates ranked at or above the 75th percentile, two of which ranked at or above the 90th percentile, which is a demonstrated improvement from the prior year rates.

Performance Area	Overall Performance Impact
Behavioral Health	**Quality, Timeliness,** and **Access**—Iowa Total Care's HEDIS measure rates for follow-up after an ED visit for AOD abuse or dependence within seven and 30 days ranked at or above the 90th percentile, demonstrating that Iowa Total Care had implemented policies, procedures, and processes to ensure members receive appropriate follow-up services after an ED visit for AOD abuse or dependence. Iowa Total Care achieved rates for the *Follow-Up After ED Visit for Mental Illness* that were at or above the 75th percentile but below the 90th percentile, and the *Follow-Up After Hospitalization for Mental Illness* indicator rates were at or above the 50th percentile but below the 75th percentile. Additionally, through the NAV activity, Iowa Total Care demonstrated a sufficient network of inpatient behavioral health providers. However, while less than 1 percent of Iowa Total Care's members did not have access to outpatient behavioral health providers within the time/distance standard, overall, Iowa Total Care's network was adequate to meet the behavioral health needs of its members. As the other Iowa MCO demonstrated a sufficient network of inpatient behavioral health providers, some providers may be reluctant to contract with Iowa Total Care which could have impacted the results of the NAV activity. Further, the *Diabetes Monitoring for People With Diabetes and Schizophrenia* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics* HEDIS measure rates ranked below the 25th percentile, indicating the greatest opportunities for Iowa Total Care to implement interventions to address appropriate provider monitoring related to these performance areas.
Women's Health	**Quality, Timeliness,** and **Access**—Iowa Total Care's *Women's Health* domain measure rates indicated that members were not receiving recommended health screenings, as the rate for *Breast Cancer Screening* was below the 25th percentile, and the rates for *Cervical Cancer Screening* and *Chlamydia Screening in Women* ranked at or above the 25th percentile but below the 50th percentile. Additionally, the *Timeliness of Prenatal Care* indicator rate also ranked below the 25th percentile. Further, while Iowa Total Care did not demonstrate significant improvement through the *Timeliness of Postpartum Care* PIP, it did show an increase in the percentage of women who accessed postpartum care through the HEDIS *Postpartum Care* measure. Iowa Total Care has implemented strategies and processes to impact the HEDIS *Postpartum Care* measure, such as a member incentive to complete a postpartum appointment within the established time frame, automated text messages to known pregnant members, and increased education about the importance of completing a notification of pregnancy assessment to members and providers. Continuance of these interventions should support continued improvement in overall outcomes for pregnant women and their babies.

Performance Area	Overall Performance Impact
Person-Centered Care Planning for LTSS Members	**Quality, Timeliness,** and **Access**—As seen through the PMV activity, of the six reportable performance measures, Iowa Total Care's performance improved for the *Provision of Care Plan*, *Person-Centered Care Plan Meeting*, *Care Team Lead Chosen by Member*, and *Member Choice of HCBS Settings* measures in CY 2022 in comparison to CY 2021. Iowa Total Care used data extracts to continuously monitor performance and address deficiencies throughout the measurement year. LTSS leadership worked closely with the CBCMs to monitor members who were not compliant with the measures and to improve documentation processes to ensure an accurate picture of performance. The impact of these interventions and Iowa Total Care's adherence to these expectations will be further assessed through future compliance reviews and specifically through the care coordination program area.
Disparities in Care	**Quality** and **Access**—Through the NAV activity, no variances were identified for the time/distance standard by member urbanicity, race/ethnicity, age, or living in an area of concentrated disadvantage, indicating that all Iowa Total Care members have equal access to providers and that there are currently no disparate groups. As part of Iowa Total Care's QAPI program that was reviewed as part of the compliance review activity, Iowa Total Care, guided by national CLAS standards, identifies and addresses clinical areas of health disparities. Further, Iowa Total Care's population health management initiatives are reviewed to assure cultural issues and social determinants of health are identified, considered, and addressed. Iowa Total Care developed a health equity approach to identify disparities, prioritize projects, and collaborate across the community to reduce disparities through targeted intervention efforts. Additionally, Iowa Total Care uses a disparity analysis which includes analyzing HEDIS measures and utilization data by eligibility category, race, ethnicity, limited English proficiency, disability, age, gender, and geography to identify priority populations and implement interventions to reduce the identified disparity. Through these initiatives, Iowa Total Care should effectively reduce disparities in care.
Member Satisfaction	**Quality**—Through the CAHPS activity, Iowa Total Care achieved scores that were statistically significantly higher than the 2021 national average for three measures across the child surveys. Further, Iowa Total Care's CAHPS Measure—*Customer Service at Child's Health Plan Gave Information or Help Needed* PIP improved from the baseline rate of 91 percent to 94.4 percent rate for Remeasurement 1. The PIP interventions implemented by Iowa Total Care appear to have contributed to the increase in positive experiences reported by members completing the survey. However, through the compliance review activity, HSAG identified that Iowa Total Care was not consistently or fully resolving member grievances which could lead to member dissatisfaction with the MCO. Iowa Total Care was required to develop a CAP to remediate the identified deficiencies which should support improvement in the grievance process.

4. Assessment of Prepaid Ambulatory Health Plan Performance

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2022 review period to evaluate the performance of PAHPs on providing quality, timely, and accessible healthcare services to DWP and Hawki members. Quality, as it pertains to EQR, means the degree to which the PAHPs increased the likelihood of members' desired outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to HHS' network adequacy standards) and §438.206 (adherence to HHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the PAHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in CY 2022 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, refer to Appendix A.

Validation of Performance Improvement Projects

For the CY 2022 validation, the PAHPs initiated new HHS-mandated PIP topics, reporting baseline data for the performance indicators. HSAG conducted validation on the PIP Design (Steps 1 through 6) and Implementation (Steps 7 and 8, as applicable) stages of the selected PIP topic for each PAHP in accordance with CMS' EQR protocol for the validation of PIPs (CMS Protocol 1). Table 4-1 outlines the selected PIP topics and performance indicators for the PAHPs.

Table 4-1—PIP Topics and Performance Indicators

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

Performance Measure Validation

Table 4-2 shows that the PAHPs were required to calculate and report. These measures were required to be reported following the measure specifications provided by HHS. HHS identified the measurement period as July 1, 2021, through June 30, 2022.

Table 4-2—List of Performance Measures for PAHPs

2022 Performance Measures Selected by HHS for Validation		
Measure Name	**Method**	**Steward**
Members With at Least Six Months of Coverage	Administrative	HHS
Members Who Accessed Dental Care	Administrative	HHS
Members Who Received Preventive Dental Care	Administrative	HHS

2022 Performance Measures Selected by HHS for Validation		
Measure Name	**Method**	**Steward**
Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation	Administrative	HHS
Members Who Received an Oral Evaluation During the Measurement Year, Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation, and Received an Oral Evaluation 6–12 Months Prior to the Oral Evaluation	Administrative	HHS
Members Who Received a Preventive Examination and a Follow-Up Examination	Administrative	HHS

Additionally, HHS 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

CY 2021 commenced a new three-year cycle of compliance reviews. The compliance reviews for the HHS-contracted PAHPs comprise 14 program areas, referred to as standards, that correlate to the federal standards and requirements identified in 42 CFR §438.358(b)(1)(iii). These standards also include applicable Iowa-specific contract requirements and areas of focus identified by HHS. HSAG conducted a review of the first seven standards in Year One (CY2021). For CY 2022, the remaining seven standards were reviewed (Year Two of the cycle). In Year Three (CY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the CY 2021 and CY 2022 compliance reviews. Table 4-3 outlines the standards reviewed over the three-year compliance review cycle.

Table 4-3—Compliance Review Standards

Standards	Associated Federal Citations[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of PAHP implementation of Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		

Standards	Associated Federal Citations[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

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

[2] The Health Information Systems standard includes an assessment of each PAHP's IS capabilities.

Network Adequacy Validation

The CY 2022 NAV activity evaluated whether the DWP Adults, DWP Kids, and Hawki members have adequate access to dental provider services available through one of the PAHPs. The analysis assessed the following dimensions of access to care:

- **Provider Capacity Analysis:** HSAG compared the number of dental providers associated with a PAHP's provider network relative to the number of enrolled members. This provider-to-member ratio represents a summary statistic used to highlight the overall capacity of a PAHP's dental provider network to deliver dental services to Medicaid members.
- **Geographic Network Distribution Analysis:** The second dimension of this study evaluated the geographic distribution of dental providers relative to member populations. For each PAHP, HSAG calculated the percentage of members within predefined access standards.

Encounter Data Validation

Since 2018, HSAG has continued to conduct the core EDV activities for the two PAHPs. In CY 2022, HSAG completed those activities, which included:

- Information systems (IS) review—assessment of HHS' and/or the PAHPs' IS and processes.

- Administrative profile—analysis of HHS' electronic encounter data accuracy, completeness, and timeliness.
- Comparative analysis—analysis of HHS' electronic encounter data accuracy and completeness through a comparison between HHS' electronic encounter data and the data extracted from the PAHPs' data systems, along with technical assistance provided to plans that performed poorly in the comparative analysis.
- Dental record review—analysis of HHS' electronic encounter data completeness and accuracy through a comparison between HHS' electronic encounter data and the information documented in the corresponding members' dental records.

While HSAG has conducted all of the core EDV activities as illustrated in Table 4-4 for both Delta Dental and MCNA Dental, it has been almost three years since the comparative analysis was conducted. As such, HSAG conducted the comparative analysis component during the CY 2022 EDV study for the two PAHPs. The goal of the comparative analysis is to evaluate the extent to which dental encounters submitted to HHS by the PAHPs are complete and accurate, based on corresponding information stored in the PAHPs' data systems. HSAG used data from both HHS and the PAHPs with dates of service between July 1, 2020, and June 30, 2021, to evaluate the accuracy and completeness of the dental encounter data.

Table 4-4—Core Evaluation Activities Since 2018

Calendar Year	PAHPs	Core Activity	Study Review Period
CY 2018	• DDIA • MCNA	Information Systems Review	NA
CY 2019	• DDIA • MCNA	Comparative Analysis	January 1, 2018—December 31, 2018
CY 2020	• DDIA • MCNA	Dental Record Review	January 1, 2019—December 31, 2019
CY 2021	• DDIA • MCNA	Administrative Profile	July 1, 2019—June 30, 2020

External Quality Review Activity Results

Delta Dental of Iowa

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of Delta Dental's PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 4-5 displays the overall validation status and the baseline results for each performance indicator.

Table 4-5—Overall Validation Rating for DDIA

PIP Topic	Validation Rating	Performance Indicators	Performance Indicator Results		
			Baseline	R1	R2
Annual Preventative Dental Visits	*Partially Met*	1. (DWP adults) The percentage of members 19 years of age and older [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	24.89%		
		2. (Hawki) The percentage of members 18 years of age and younger [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	61.09%		
		3. (DWP kids) The percentage of members 18 years of age and younger [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	49.88%		

R1 = Remeasurement 1
R2 = Remeasurement 2
= Baseline data only; no remeasurement data reported.

The goal for Delta Dental's PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 4-6 displays the interventions, as available, initiated by the PAHP to support achievement of the PIP goal and address the barriers identified through QI and causal/barrier analysis processes.

Table 4-6—Baseline Interventions for DDIA

Intervention Descriptions
The PAHP had not progressed to implementing interventions for this PIP topic. Interventions for this PIP topic will be reported in the next annual EQR report.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Delta Dental's Aim statement set the focus of the project, and the framework for data collection, analysis, and interpretation. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Delta Dental had opportunities to improve its documentation specific to defining the project's eligible population and describing the performance indicator in alignment with the HHS-defined specifications. The gaps identified in the data collection process will impact the accuracy of the data reported. [**Quality**]

Why the weakness exists: Delta Dental did not follow the HHS-defined performance indicator specifications in the design of the project.

Recommendation: HSAG recommends that Delta Dental follow the HHS-defined specifications for collecting and reporting the performance indicator results.

Performance Measure Validation

Performance Results

HSAG reviewed Delta 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, Delta 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 Delta Dental's processes. During the interview component of the review, PSV was completed. Delta Dental 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's data integration and measure reporting processes were adequate and ensured data integrity and accuracy.

Table 4-7 displays measure designations and reportable measure rates for DWP Adults, Table 4-8 displays measure designations and reportable measure rates for DWP Kids, and Table 4-9 displays measure designations and reportable measure rates for the Hawki Dental Plan. Delta Dental received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 4-7—2022 DDIA Performance Measure Designations and Rates for DWP Adults

Performance Measure		2020 Rate	2021 Rate	2022 Measure Designation	2022 Results		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	220,844	246,053	*R*	268,860	—	—
2	*Members Who Accessed Dental Care*	34.15%	30.97%	*R*	268,860	78,204	29.09%
3	*Members Who Received Preventive Dental Care*	75.10%	75.49%	*R*	78,204	56,252	71.93%
4	*Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation*	45,146	48,653	*R*	49,259	—	—
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*	29,326	26,657	*R*	—	29,405	—
6	*Members Who Received a Preventive Examination and a Follow-Up Examination*	64.96%	54.79%	*R*	49,259	29,405	59.69%

— A dash indicates a value is not applicable to the performance measure.

Table 4-8—2022 DDIA Performance Measure Designations and Rates for DWP Kids

Performance Measure		2022 Measure Designation	2022 Results		
			Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	*R*	189,938	—	—
3	*Members Who Received Preventive Dental Care*	*R*	189,938	89,646	47.20%

— A dash indicates a value is not applicable to the performance measure.

Table 4-9—2022 DDIA Performance Measure Designations and Rates for Hawki Dental Plan

Performance Measure		2022 Measure Designation	2022 Results		
			Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	*R*	60,642	—	—
3	*Members Who Received Preventive Dental Care*	*R*	60,642	34,098	56.23%

— A dash indicates a value is not applicable to the performance measure.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Delta Dental closely monitored performance results of the preventive measures to identify opportunities for improvement through outreach campaigns. Delta Dental monitored measure rates monthly and used the data on members missing services to run outreach campaigns using multiple methods of communication (e.g., postcards, text messages). As part of the outreach campaigns, Delta Dental monitored the success of different modes of communication and reported that success seemed to vary based on age. Additionally, Delta Dental used claims data and assessed its commercial network for Medicaid contracting opportunities to help identify providers to serve a particular area that includes members who have a high rate of missing preventive services. [**Quality** and **Access**]

Strength #2: To increase dental providers in underserved areas, Delta Dental participates in the Fulfilling Iowa's Need for Dentists (FIND) program, which offers dental school tuition reimbursement and loan repayment services, with a requirement that graduates participate in Medicaid and government programs. [**Access**]

Weaknesses and Recommendations

Weakness: During PSV, HSAG observed a claim that had been manually adjusted by a claims processor, with a note indicating that the service rendered differed from the Current Dental Terminology (CDT) code on the adjudicated claim. [**Quality**]

Why the weakness exists: Delta Dental noted that the error was due to a specific claims processor's isolated action that differed from Delta Dental's established policy for processing claims. Delta Dental confirmed that no additional claims were impacted by this issue, and that it implemented

additional source code updates which would identify such manual edits, removing them should they occur in the future.

Recommendation: Although Delta Dental confirmed that there were no additional claims impacted by this situation, and the identified claim's correct CDT code was still a preventive service within the performance measure value set, Delta Dental should take corrective action to ensure this issue does not recur, considering that the potential downstream impact creates risk not only for performance measure reporting but for other areas as well. For example, Delta Dental should consider running a routine report that flags all manually adjusted claims for 100 percent review to ensure accuracy of payment and coding in the adjustment process.

Compliance Review

Performance Results

Table 4-10 presents Delta Dental's compliance scores for each standard evaluated during the current three-year compliance review cycle. Delta Dental was required to submit a CAP for all standards scoring less than 100 percent compliant. Delta Dental's implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 4-10—Summary of Standard Compliance Scores for DDIA

Compliance Review Standards	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (CY 2021)		
Standard I—Disenrollment: Requirements and Limitations	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**82%**
Standard III—Emergency and Poststabilization Services	§438.114	**70%**
Standard IV—Availability of Services	§438.206	**100%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**
Standard VI—Coordination and Continuity of Care	§438.208	**100%**
Standard VII—Coverage and Authorization of Services	§438.210	**90%**
Year Two (CY 2022)		
Standard VIII—Provider Selection	§438.214	**75%**
Standard IX—Confidentiality	§438.224	**91%**
Standard X—Grievance and Appeal Systems	§438.228	**84%**

Compliance Review Standards	Associated Federal Citations[1]	Compliance Score
Standard XI—Subcontractual Relationships and Delegation	§438.230	**60%**
Standard XII—Practice Guidelines	§438.236	**83%**
Standard XIII—Health Information Systems[2]	§438.242	**85%**
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	**88%**
Year Three (CY 2023)		
Review of PAHP implementation of Year One and Year Two CAPs		

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

[2] The Health Information Systems standard includes an assessment of the PAHP's information system.

Table 4-11 presents Delta Dental's scores for each standard evaluated during the CY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in Delta Dental's written documents, including policies, procedures, reports, and meeting minutes; and interviews with PAHP staff members. The CY 2022 Compliance Review activity demonstrated how successful Delta Dental was in interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with HHS.

Table 4-11—CY 2022 Standard Compliance Scores for DDIA

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	10	8	6	2	2	**75%**
Standard IX—Confidentiality	11	11	10	1	0	**91%**
Standard X—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard XI—Subcontractual Relationships and Delegation	5	5	3	2	0	**60%**
Standard XII—Practice Guidelines	6	6	5	1	0	**83%**
Standard XIII—Health Information Systems	13	13	11	2	0	**85%**
Standard XIV—Quality Assessment and Performance Improvement Program	10	8	7	1	2	**88%**
Total	**93**	**89**	**74**	**15**	**4**	**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

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

Strengths

Strength #1: HSAG did not identify any strengths for Delta Dental through the compliance review activity as no program areas reviewed were fully compliant.

Weaknesses and Recommendations

Weakness #1: Delta Dental received a score of 75 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with contractual requirements. [**Quality**]

Why the weakness exists: Delta Dental did not demonstrate that it included required credentialing attestations or documented follow-up on adverse responses to the credentialing attestations provided by the practitioner. Additionally, recredentialing of two practitioners occurred outside the 36-month time frame requirement.

Recommendation: Delta Dental was required to develop a CAP which was subsequently approved by HHS. HSAG recommends that the PAHP ensure processes are in place to fully implement its CAP and remediate any deficiencies noted through the compliance review activity.

Weakness #2: Delta Dental received a score of 60 percent in the Subcontractual Relationships and Delegation program area, indicating gaps in the PAHP's process for ensuring its delegation agreements include all required federal and State contractual provisions. [**Quality**]

Why the weakness exists: Two of the delegation agreements reviewed as part of the case file review did not contain a scope of work or detailed description of the delegated activities. Additionally, the PAHP was unable to demonstrate that the PAHP had a formalized process for and maintained documentation of the oversight and monitoring of the PAHP's delegates.

Recommendation: While Delta Dental was required to develop a CAP which was subsequently approved by HHS, HSAG recommends that the PAHP have processes in place to ensure the CAPs are fully implemented.

Network Adequacy Validation

Performance Results

Table 4-12 illustrates the provider ratios for Delta Dental's DWP, DWP Kids, and Hawki provider networks.

Table 4-12—DDIA Provider Ratios

Provider Category	Number of Unique Providers	Provider-to-Member Ratio
DDIA DWP		
General Dentist	764	1:343
Endodontist	11	1:23,818
Oral Surgeon	48	1:5,459
Periodontist	11	1:23,818
Prosthodontist	23	1:11,391
DDIA DWP Kids		
General Dentist	763	1:250
Endodontist	11	1:17,312
Oral Surgeon	48	1:3,968
Orthodontist	52	1:3,663
Pedodontist	76	1:2,397
Periodontist	11	1:17,312
Prosthodontist	23	1:8,280
DDIA Hawki		
General Dentist	1,042	1:58
Endodontist	15	1:3,993
Oral Surgeon	61	1:982
Orthodontist	51	1:1,175
Pedodontist	84	1:673
Periodontist	11	1:5,445
Prosthodontist	25	1:2,396

Table 4-13 shows the percentage of Delta Dental members with access to general dentists within the time/distance standards for the DWP, DWP Kids, and Hawki networks.

Table 4-13—Percentage of Members With Access to General Dentists Within the Time/Distance Standards—DDIA

PAHP	Percentage of Members With Access to General Dentists Within the Time/Distance Standards			
	Full Network[1]		Active Network[2]	
	Rural (60 miles or 60 minutes)	Urban (30 miles or 30 minutes)	Rural (60 miles or 60 minutes)	Urban (30 miles or 30 minutes)
DDIA				
DWP	100.0%	100.0%	100.0%	100.0%
DWP Kids	100.0%	100.0%	100.0%	100.0%
Hawki	100.0%	100.0%	100.0%	100.0%

[1] Full network includes all providers submitted who were eligible for inclusion in the Dental Provider Network Analysis.
[2] Active network is restricted to those full network providers who have seen at least five members in the past 12 months and otherwise meet the inclusion criteria for the Dental Provider Network Analysis.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Whether using the full or active provider network, all Delta Dental members have access to general dentists within the time/distance standards. [**Timeliness** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for Delta Dental through the NAV activity.

Why the weakness exists: NA

Recommendation: NA

Encounter Data Validation

Performance Results

Table 4-14 displays the percentage of records present in the files submitted by Delta Dental that were not found in HHS' files (record omission), and the percentage of records present in HHS' files but not present in the files submitted by Delta Dental (record surplus). **Lower rates indicate better performance for both record omission and record surplus.**

Table 4-14—Record Omission and Surplus for DDIA

Record Omission	Record Surplus
1.2%	0.8%

Table 4-15 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the dental encounters for Delta Dental. 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, neither lower nor higher rates indicate better or worse performance.

Table 4-15—Element Omission, Surplus, Absent, and Accuracy: DDIA

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy[1]
Member ID	0.0%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	0.0%	>99.9%
Detail Service From Date	0.0%	0.0%	0.0%	99.7%
Detail Service To Date	0.0%	0.0%	0.0%	99.7%
Billing Provider National Provider Identifier (NPI)	0.0%	0.0%	0.0%	97.6%
Rendering Provider NPI	0.0%	0.0%	0.0%	>99.9%
CDT Code	0.0%	0.0%	0.0%	99.8%
Units of Service	0.0%	0.0%	0.0%	>99.9%
Tooth Number	<0.1%	<0.1%	75.3%	99.9%
Tooth Surface 1	11.2%	0.0%	88.8%	NA
Tooth Surface 2	7.5%	0.0%	92.5%	NA
Tooth Surface 3	2.8%	0.0%	97.2%	NA
Tooth Surface 4	0.8%	0.0%	99.2%	NA
Tooth Surface 5	0.1%	0.0%	99.9%	NA
Oral Cavity Code 1	<0.1%	<0.1%	97.7%	89.9%

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy[1]
Oral Cavity Code 2	0.0%	0.0%	100.0%	NA
Oral Cavity Code 3	0.0%	0.0%	100.0%	NA
Oral Cavity Code 4	0.0%	0.0%	100.0%	NA
Oral Cavity Code 5	0.0%	0.0%	100.0%	NA
Detail Paid Amount	0.0%	0.0%	0.0%	98.8%
Header Paid Amount	0.0%	0.0%	0.0%	>99.9%

NA indicates that there were no values present in either data sources for that data element.
[1] Element Accuracy displays the percentage of records with the same values in Delta Dental's submitted files and HHS' submitted files for each key data element associated with the dental encounters.

Table 4-16 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 associated with the dental encounter data type.

Table 4-16—All-Element Accuracy: DDIA

Number of Records in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
1,041,981	888,801	85.3%

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Delta Dental's dental encounter data appeared complete when comparing data extracted from Delta Dental's claims systems to data extracted from HHS' data warehouse. Encounter data records from HHS-submitted files were highly corroborated in Delta Dental-submitted files. [**Quality**]

Strength #2: Encounter data element comparison between data extracted from Delta Dental's claims systems and data extracted from HHS' data warehouse also showed complete and accurate data for most data elements evaluated. [**Quality**]

Weaknesses and Recommendations

Weakness #1: *Tooth Surface* information was captured without values in HHS' Medicaid Management Information System (MMIS). Additionally, when *Oral Cavity Code* values were compared to values within HHS' data, some values did not match. [**Quality**]

Why the weakness exists: It appears the *Tooth Surface* information may not have been transmitted to HHS in the encounter data as expected. At the time the comparative analysis ended, HHS acknowledged that an ongoing effort with Delta Dental is in progress to investigate the root cause(s) associated with the *Tooth Surface* data elements not being captured in HHS' MMIS. HHS also acknowledged that it will determine the course of action to remediate corrections, if applicable, to ensure that the encounter data within HHS' MMIS are complete and accurate. Regarding the *Oral Cavity Code* values mismatched, Delta Dental-submitted data had fewer detail lines when compared to the HHS-submitted data, which led to misalignment in the population of data elements.

Recommendation: While Delta Dental noted that it had discussed the discrepancies related to the data elements with HHS, HSAG recommends that Delta Dental continue to work with HHS to resolve the discrepancy issue.

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

HSAG performed a comprehensive assessment of Delta Dental's aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within Delta Dental that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how Delta Dental's overall performance contributed to the Iowa Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 4-17 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to Delta Dental Medicaid members.

Table 4-17—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Preventive Dental Care	**Quality**, **Timeliness**, and **Access**—While HHS required the PAHP to initiate an annual dental visit PIP, Delta Dental's validation results of *Partially Met* indicated opportunities to improve its documentation specific to defining the eligible population and describing the performance indicator in alignment with HHS-defined specifications impacting the accuracy of Delta Dental's reported data for the PIP activity. The baseline rates for the DWP Adults, DWP Kids, and Hawki populations varied greatly (24.89 percent, 49.88 percent, and 61.09 percent, respectively). As such, Delta Dental should continue to explore factors influencing the rates for its different populations. Further, as seen through the PMV activity, the rates for the *Members Who Receive Preventive Dental Care* measure were relatively low, with 71.93 percent for DWP Adults, 47.20 percent for DWP Kids, and 56.23 percent for Hawki. Delta Dental met all the time/distance standards assessed through the NAV activity, indicating that Delta Dental had a sufficient dental network of providers to provide preventive dental care. While it had a sufficient dental

Performance Area	Overall Performance Impact
	network, Delta Dental reported through the PIP activity a decrease in dental providers accepting new patients which may affect members' access to dental care. While Delta Dental's PIP has yet to progress to implementing interventions, Delta Dental reported through the PIP validation activity that its QAPI committee will identify barriers and initiate appropriate interventions. Well-designed targeted interventions should impact access to preventive dental services as reported through future PIP and PMV activities.
Utilization of Dental Services	**Quality**, **Timeliness**, and **Access**—Through the PMV activity, Delta Dental achieved the following rates for HHS-required performance measures: • *Members Who Access Dental Care* (DWP Adults)—29.09 percent • *Members Who Received Preventive Dental Care* (DWP Adults)—71.93 percent • *Members Who Received a Preventive Examination and a Follow-up Examination* (DWP Adults)—59.69 percent • *Members Who Received Preventive Dental Care* (DWP Kids)—47.20 percent • *Members Who Received Preventive Dental Care* (Hawki)—56.23 percent While these measure specifications are Iowa-specific, and a national comparison is not available, several opportunities exist to improve the utilization of dental services across Delta Dental's Iowa managed care membership. Delta Dental met all the time/distance standards assessed through the NAV activity, indicating that Delta Dental had a sufficient dental network of providers to provide dental care. Through the compliance review activity, several opportunities to enhance Delta Dental's QAPI program were identified. As Delta Dental enhances its QAPI program based on HSAG's recommendations, Delta Dental should consider additional PIPs or quality initiatives to incorporate into the QAPI program focused on increasing dental utilization overall.

Managed Care of North America Dental

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of MCNA Dental's PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 4-18 displays the overall validation status and the baseline results for each performance indicator.

Table 4-18—Overall Validation Rating for MCNA

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
Increase the Percentage of Dental Services	*Met*	1. The percentage of members 19 years of age and older who had at least one preventive dental visit during the measurement year.	61.70%		
		2. The percentage of members 18 years of age and younger who had at least one preventive dental visit during the measurement year.	35.86%		

R1 = Remeasurement 1
R2 = Remeasurement 2
= Baseline data only; no remeasurement data reported.

The goal for MCNA Dental's PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 4-19 displays the interventions, as available, initiated by the PAHP to support achievement of the PIP goal and address the barriers identified through QI and causal/barrier analysis processes.

Table 4-19—Baseline Interventions for MCNA

Intervention Descriptions
The PAHP had not progressed to implementing interventions for this PIP topic. Interventions for this PIP topic will be reported in the next annual EQR report.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MCNA Dental developed a methodologically sound improvement project and collected and reported accurate performance indicators using a systematic data collection process for its PIP. [**Quality**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for MCNA Dental through the PIP activity.

Why the weakness exists: NA

Recommendation: NA

Performance Measure Validation

Performance Results

HSAG reviewed MCNA 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, MCNA 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 MCNA Dental's processes. During the interview component of the review, the member-level data used by MCNA Dental to calculate the performance measure rates were readily available for the auditor's review. MCNA Dental was able to report valid and reportable rates. HSAG determined that MCNA Dental's data integration and measure reporting processes were adequate and ensured data integrity and accuracy.

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

Table 4-20—2022 MCNA Performance Measure Designations and Rates for DWP Adults

	Performance Measure	2020 Rate	2021 Rate	2022 Measure Designation	2022 Results		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	116,131	138,535	*R*	160,048	—	—
2	*Members Who Accessed Dental Care*	19.76%	18.57%	*R*	160,048	27,666	17.29%
3	*Members Who Received Preventive Dental Care*	63.13%	65.11%	*R*	27,666	17,070	61.70%
4	*Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation*	9,860	12,499	*R*	13,729	—	—
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*	4,165	4,288	*R*	—	5,439	—
6	*Members Who Received a Preventive Examination and a Follow-Up Examination*	42.24%	34.31%	*R*	13,729	5,439	39.62%

— A dash indicates a value is not applicable to the performance measure.

Table 4-21—2022 MCNA Performance Measure Designations and Rates for DWP Kids

	Performance Measure	2022 Measure Designation	2022 Results		
			Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	*R*	122,314	—	—
3	*Members Who Received Preventive Dental Care*	*R*	122,314	43,862	35.86%

— A dash indicates a value is not applicable to the performance measure.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MCNA Dental ensured that all billing and rendering providers were Medicaid enrolled. MCNA Dental indicated that it identified these providers through its encounter data reconciliation process with HHS, as well as through internal monitoring efforts, to ensure providers with multiple NPIs have notified Iowa Medicaid of each NPI to initiate the Medicaid enrollment for all applicable NPIs. [**Quality**]

Strength #2: MCNA Dental continued using Practice Site Performance Summary Reports which it distributed to all providers. The reports contained quarterly updates on several operational and clinical performance trends. MCNA Dental tracked preventive and treatment service rates for adults quarterly within the reports, allowing providers to view their performance trend quarter-over-quarter, along with a comparison to peer rates for preventive and treatment services for the current quarter. The implementation of this report has supported MCNA Dental to target individual practice performance that needs attention while encouraging providers to take more responsibility for the rates of preventive services within their practices. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: MCNA Dental included expired CDT codes in its preliminary rate reporting template that were not part of the HHS 2022 PAHP Performance Measures Technical Specifications. [**Quality**]

Why the weakness exists: MCNA Dental alerted HHS in January 2022 by email that the HHS Reporting Template included some deleted CDT codes for preventive services provided to the DWP Kids population that had been replaced with updated codes by the American Dental Association (ADA) in 2019 and 2020. In response, HHS indicated to MCNA Dental that the HHS Reporting Template would be updated and recommended that MCNA Dental report DWP Kids measure data using the updated code list that MCNA Dental had provided. MCNA Dental assumed that it should still include the deleted codes in reporting for the 2022 PMV activity since performance measure stewards sometimes keep deleted codes in a value set for a transition period. However, in the updated Reporting Template HHS provided to HSAG for the 2022 PMV activity, the deleted codes were not included. HSAG confirmed with HHS during PMV that HHS did not want to allow the deleted codes in the 2022 performance measure rates. At HSAG's request, MCNA Dental removed the services associated with the deleted codes from its Rate Reporting Template for the PMV activity and resubmitted updated measure rates. Removal of the deleted service codes did not make a

material impact to the performance measure rate for the DWP Kids population since it only involved six dental claims.

Recommendation: HSAG recommends that MCNA Dental promptly outreach to HHS regarding any PAHP Performance Measures Technical Specifications interpretation questions and verify proposed changes to the specifications as documented in the published HHS Reporting Template and/or Technical Specifications document prior to submitting the Rate Reporting Template for annual performance measure validation. Additionally, HSAG recommends that MCNA Dental closely review any future technical specification revisions.

Compliance Review

Performance Results

Table 4-22 presents MCNA Dental's compliance scores for each standard evaluated during the current three-year compliance review cycle. MCNA Dental was required to submit a CAP for all standards scoring less than 100 percent compliant. MCNA Dental's implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 4-22—Summary of Standard Compliance Scores for MCNA

Compliance Review Standards	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (CY 2021)		
Standard I—Disenrollment: Requirements and Limitations	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**88%**
Standard III—Emergency and Poststabilization Services	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**100%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**
Standard VI—Coordination and Continuity of Care	§438.208	**86%**
Standard VII—Coverage and Authorization of Services	§438.210	**100%**
Year Two (CY 2022)		
Standard VIII—Provider Selection	§438.214	**100%**
Standard IX—Confidentiality	§438.224	**100%**
Standard X—Grievance and Appeal Systems	§438.228	**95%**
Standard XI—Subcontractual Relationships and Delegation	§438.230	**60%**

Compliance Review Standards	Associated Federal Citations[1]	Compliance Score
Standard XII—Practice Guidelines	§438.236	**100%**
Standard XIII—Health Information Systems[2]	§438.242	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	**100%**
Year Three (CY 2023)		
Review of PAHP implementation of Year One and Year Two CAPs		

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

[2] The Health Information Systems standard includes an assessment of the PAHP's IS capabilities.

Table 4-23 presents MCNA Dental's scores for each standard evaluated during the CY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in MCNA Dental's written documents, including policies, procedures, reports, and meeting minutes; and interviews with PAHP staff members. The CY 2022 Compliance Review activity demonstrated how successful MCNA Dental was in interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with HHS.

Table 4-23—CY 2022 Standard Compliance Scores for MCNA

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	10	8	8	0	2	**100%**
Standard IX—Confidentiality	11	11	11	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	36	2	0	**95%**
Standard XI—Subcontractual Relationships and Delegation	5	5	3	2	0	**60%**
Standard XII—Practice Guidelines	6	6	6	0	0	**100%**
Standard XIII—Health Information Systems	13	13	13	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	10	8	8	0	2	**100%**
Total	**93**	**89**	**85**	**4**	**4**	**96%**

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MCNA Dental achieved full compliance for the Provider Selection program area, demonstrating that the PAHP had appropriate and thorough credentialing and recredentialing policies, procedures, and practices in place for the selection and retention of network providers, which also support that contracted providers met the requirements and standards for participating in the PAHP's provider network. [**Quality**, **Timeliness**, and **Access]**

Strength #2: MCNA Dental achieved full compliance for the Confidentiality program area, demonstrating that the PAHP had appropriate policies and processes for the use and disclosure of members' PHI and members' privacy rights, and provided required notices related to privacy practices. [**Quality**]

Strength #3: MCNA Dental achieved full compliance for the Practice Guidelines program area, demonstrating that the PAHP adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines. [**Quality and Access**]

Strength #4: MCNA Dental achieved full compliance for the Health Information Systems program area, demonstrating that the PAHP maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. [**Quality**, **Timeliness**, and **Access**]

Strength #5: MCNA Dental achieved full compliance for the Quality Assessment and Performance Improvement Program area, demonstrating that the PAHP established and maintained an ongoing comprehensive QAPI program for the services it furnishes to members that addressed availability, accessibility, coordination, and continuity of care of services through detailed program objectives, performance measures, and monitoring of outcomes. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: MCNA Dental received a score of 60 percent in the Subcontractual Relationships and Delegation program area, indicating gaps in the PAHP's process for ensuring its contracts or written arrangements with delegates included all required federal and State contractual provisions. **[Quality]**

Why the weakness exists: Of the delegation agreements reviewed as part of the case file review, MCNA Dental did not consistently include a provision indicating that the delegate agreed to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and

contract provisions. The delegation agreements also did not consistently include the required right to audit provisions.

Recommendation: While MCNA Dental was required to develop a CAP that was subsequently approved by HHS, HSAG recommends that the PAHP have processes in place to ensure the CAPs are fully implemented.

Network Adequacy Validation

Performance Results

Table 4-24 illustrates the provider ratios for MCNA Dental's DWP and DWP Kids provider networks.

Table 4-24—MCNA Provider Ratios

Provider Category	Number of Unique Providers	Provider-to-Member Ratio
MCNA DWP		
General Dentist	507	1:304
Endodontist	15	1:10,252
Oral Surgeon	30	1:5,126
Periodontist	17	1:9,046
Prosthodontist	21	1:7,323
MCNA DWP Kids		
General Dentist	507	1:246
Endodontist	15	1:8,293
Oral Surgeon	30	1:4,147
Orthodontist	28	1:4,443
Pedodontist	66	1:1,805
Periodontist	17	1:7,317
Prosthodontist	25	1:5,924

Table 4-25 shows the percentage of MCNA Dental members with access to general dentists within the time/distance standards for the DWP and DWP Kids networks.

Table 4-25—Percentage of Members With Access to General Dentists Within the Time/Distance Standards—MCNA

PAHP	Percentage of Members With Access to General Dentists Within the Time/Distance Standards			
	Full Network[1]		Active Network[2]	
	Rural (60 miles or 60 minutes)	Urban (30 miles or 30 minutes)	Rural (60 miles or 60 minutes)	Urban (30 miles or 30 minutes)
MCNA				
DWP	100.0%	99.9%	100.0%	99.9%
DWP Kids	100.0%	99.9%	100.0%	99.9%

[1] Full network includes all providers submitted who were eligible for inclusion in the Dental Provider Network Analysis.
[2] Active network is restricted to those full network providers who have seen at least five members in the past 12 months and otherwise meet the inclusion criteria for the Dental Provider Network Analysis.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Whether using the full or active provider network, all rural MCNA Dental members have access to general dentists within the time/distance standards. [**Timeliness** and **Access**]

Weaknesses and Recommendations

Weakness #1: Less than 0.1 percent of urban members did not have access to a general dentist within the time/distance standard of 30 miles or 30 minutes. This noncompliance was associated with both the full and active network. [**Timeliness** and **Access**]

Why the weakness exists: The percentage of members without access to a general dentist within the time/distance standards is quite small. This may exist due to members living in the outskirts of urban areas.

Recommendation: Since the percentage of members with access to a general dentist is very high, HSAG recommends that MCNA Dental continue to monitor the provider network to ensure the percentage of members with access does not decrease and consider contracting with additional providers as available.

Encounter Data Validation

Performance Results

Table 4-26 displays the percentage of records present in the files submitted by MCNA Dental that were not found in HHS' files (record omission), and the percentage of records present in HHS' files but not present in the files submitted by MCNA Dental (record surplus). **Lower rates indicate better performance for both record omission and record surplus**.

Table 4-26—Record Omission and Surplus: MCNA

Record Omission	Record Surplus
8.2%	3.4%

Table 4-27 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the dental encounters for MCNA Dental. For the element omission and surplus indicators, lower rates indicate better performance, whereas for the element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, neither lower nor higher rates indicate better or worse performance.

Table 4-27—Element Omission, Surplus, Absent, and Accuracy: MCNA

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy[1]
Member ID	0.0%	0.0%	0.0%	100.0%
Header Service From Date	0.0%	0.0%	0.0%	99.7%
Header Service To Date	0.0%	0.0%	0.0%	99.7%
Detail Service From Date	0.0%	0.0%	0.0%	99.9%
Detail Service To Date	0.0%	0.0%	0.0%	99.9%
Billing Provider NPI	0.0%	0.0%	0.0%	97.1%
Rendering Provider NPI	0.0%	0.0%	0.0%	100.0%
CDT Code	0.0%	0.0%	0.0%	96.7%
Units of Service	0.0%	0.0%	0.0%	99.7%
Tooth Number	5.8%	0.3%	59.5%	97.5%
Tooth Surface 1	0.2%	0.2%	88.3%	58.4%
Tooth Surface 2	0.2%	0.1%	91.8%	41.9%
Tooth Surface 3	0.1%	0.1%	96.4%	14.2%
Tooth Surface 4	<0.1%	<0.1%	98.9%	12.7%
Tooth Surface 5	<0.1%	<0.1%	99.8%	1.1%
Oral Cavity Code 1	36.9%	0.8%	60.3%	1.3%
Oral Cavity Code 2	0.0%	0.0%	100.0%	NA

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy[1]
Oral Cavity Code 3	0.0%	0.0%	100.0%	NA
Oral Cavity Code 4	0.0%	0.0%	100.0%	NA
Oral Cavity Code 5	0.0%	0.0%	100.0%	NA
Detail Paid Amount	0.0%	0.0%	0.0%	96.3%
Header Paid Amount	0.0%	0.0%	0.0%	96.7%

NA indicates that there were no values present in either data sources for that data element.
[1] Element Accuracy displays the percentage of records with the same values in MCNA's submitted files and HHS' submitted files for each key data element associated with the dental encounters.

Table 4-28 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 associated with the dental encounter data type.

Table 4-28—All-Element Accuracy: MCNA

Number of Records in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
229,835	94,711	41.2%

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Encounter data element comparison between data extracted from MCNA Dental's claims systems and data extracted from HHS' data warehouse showed complete and accurate data for most data elements evaluated. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Errors in data files extracted for the study were observed wherein the MCNA Dental-submitted encounters for the study included encounters that were not in their final status, as had been requested. Consequently, the errors resulted in discrepancies when compared to the HHS-submitted data. [**Quality**]

Why the weakness exists: It appears that MCNA Dental included the adjusted records that were not in the final status as HSAG had requested.

Recommendation: HSAG recommends that MCNA Dental implement standard quality controls to ensure accurate data extracts as requested. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced.

Weakness #2: Tooth information (i.e., *Tooth Number* and *Oral Cavity Code*) showed that information was found in the MCNA Dental-submitted data but not in the HHS-submitted data. [**Quality**]

Why the weakness exists: MCNA Dental noted that *Tooth Number* information was included in claims received from its provider; however, this information was not sent on the encounter since the service did not require the *Tooth Number* for submission. MCNA Dental also noted that for *Oral Cavity Code*, it calculated and reported the values on the extract for the study.

Recommendation: HSAG recommends that MCNA Dental work with its contracted dental providers regarding encounter data submissions, dental record documentation, and coding practices. Additionally, HSAG recommends that MCNA Dental work with HHS to confirm and ensure data submissions meet HHS' requirements.

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

HSAG performed a comprehensive assessment of MCNA Dental's aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within MCNA Dental that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how MCNA Dental's overall performance contributed to the Iowa Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 4-29 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to MCNA Dental Medicaid members.

Table 4-29—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Access to Preventive Dental Care	**Quality**, **Timeliness**, and **Access**—MCNA Dental initiated a new PIP topic, *Increase the Percentage of Dental Services.* MCNA Dental's *Met* validation results indicated that the PAHP designed a methodologically sound PIP. Consistent with the reported rates through the PMV activity, the PIP baseline rate for members 19 years of age and older (DWP Adults) was 61.70 percent, and the baseline for members 18 years of age and younger (DWP Kids) was 35.86 percent. MCNA Dental should continue to explore factors influencing the rates for its different populations as the rate for the *Members Who Receive Preventive Dental Care* measure was relatively low at 61.70 percent for DWP Adults and also low at 35.86 percent for DWP Kids. MCNA Dental met all of the time/distance standards assessed through the NAV activity for rural areas and 99.9 percent for urban areas, indicating that MCNA Dental had a sufficient dental network of providers to provide preventive dental care. While less than 1 percent of MCNA Dental's members residing in urban areas did not have access to a general dentist within the time/distance standard, this should not significantly impact lower utilization of preventive dental care.

Performance Area	Overall Performance Impact
	While MCNA Dental's PIP has yet to progress to implementing interventions, well-designed targeted interventions should impact access to preventive dental services as reported through future PIP and PMV activities.
Utilization of Dental Services	**Quality**, **Timeliness**, and **Access**—Through the PMV activity, HHS prescribed measures achieved the following rates: • *Members Who Accessed Dental Care* (DWP Adults)—17.29 percent • *Members Who Received Preventive Dental Care* (DWP Adults)—61.70 percent • *Members Who Received a Preventive Examination and a Follow-up Examination* (DWP Adults)—39.62 percent • *Members Who Received Preventive Dental Care* (DWP Kids)—35.86 percent While these measure specifications are Iowa-specific, and a national comparison is not available, several opportunities are present to improve the utilization of dental services across MCNA Dental's Iowa managed care membership. MCNA Dental demonstrated an overall sufficient dental network of providers through the NAV activity, indicating that MCNA Dental had a sufficient dental network of providers to provide dental care. Through the compliance review activity, MCNA Dental demonstrated a comprehensive QAPI program in which additional PIPs or quality initiatives could be incorporated to increase dental utilization overall.

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the CY 2022 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 2021 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, Inc.

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: **PMV Results** • Although Amerigroup indicated that it had standardized the manual review process including the implementation of training and quality assurance efforts and was not moving toward automation, HSAG continued to recommend that Amerigroup consider initiating an information technology (IT) project to create reportable fields within the HIP platform service plan and contact forms and provide its analytics team with back-end access to the platform to extract the data using SQL code as used for measures #1 and #2. This investment of IT resources would create savings over the long term through preserving clinical staff time for clinical activities. It would also allow for future capabilities to report the data administratively should the MCO technical specifications be adjusted to include administrative reporting. **HEDIS Results** • Amerigroup should partner with primary care and obstetrics and gynecology (OB-GYN) providers to conduct a focused study to determine why some female members 16 to 24 years of age who identified as sexually active were not getting screened for chlamydia to reduce the potential for serious and irreversible complications such as pelvic inflammatory disease and infertility. In addition, HSAG recommended that Amerigroup conduct a focused study that examines rates of prenatal and postpartum care across different geographic regions and different racial/ethnic groups to determine why some female members were not receiving timely prenatal or postpartum care and whether any health disparities might be impacting the rates at which women access healthcare during pregnancy. Upon identification of a root cause, Amerigroup should implement appropriate interventions (e.g., promotion of telehealth services, member incentives, provider education, and/or partnerships) to improve low performance rates within the Women's Health domain. • Amerigroup should partner with providers such as community mental health centers that treat the severe and persistently mentally ill (SPMI) population to conduct a root cause analysis or focused study to determine why members with severe mental illnesses are not being screened for diabetes or monitored for metabolic functioning. Upon identification of a root cause, Amerigroup should work with providers to

implement appropriate interventions (e.g., process improvements, patient education campaigns, provider incentives) to improve the performance rates of these measures.

- Amerigroup should partner with pediatricians, child psychiatrists, and other prescribers who treat ADHD in children to conduct a root cause analysis or focused study to identify the barriers to medication management. Upon identification of a root cause, Amerigroup should work with providers to implement appropriate interventions (e.g., promotion of telehealth services) to improve the performance rates for these measures.

MCP's Response

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

PMV

We have worked with our data analytics team to extract data from the corresponding sections of the member's PCSP where the performance measure documentation would potentially be located. The difficulty we have faced is the reliability of the data to capture the performance measures which are in a narrative format within the Person-Centered Support Plan (PCSP). While we were able to pull the information from each section of the PCSP where the performance measure evidence should be indicated, the reviewer must read each narrative section to ensure the information is present. The health plan also notes that due to the nature of the performance measures and the focus on the interactive components (member's participation in the planning process, etc.), the evidence of these measures is often found in a narrative format versus a checkbox format. This makes extrapolating the data more challenging as well. It is our hope to improve this process for upcoming reviews. For those members who are Habilitation and Children's Mental Health Waiver, their care plans are housed externally with our Integrated Health Homes and due to this, will require manual review.

HEDIS

Chlamydia Screening (CHL)

- Amerigroup Iowa continues to educate Primary Care and expanded education to OB- GYN providers to improve the HEDIS rate such as: a monthly Quality resource email, CHL measure education, provide Gap in Care reports, continued to educate and initiate supplemental EMR data exchange connections.
- Amerigroup continues to monitor denominator and numerator fluctuations through monthly HEDIS rates and monthly benchmark reports. A root cause analysis was initiated and reviewed with the HEDIS Task Force workgroup consisting of interdepartmental associates. We continue to review HEDIS rates and identify barriers and solutions to improve rates a minimum of quarterly.
- Amerigroup Iowa also reviewed member educational resources and developed a member-focused SMS (text) campaign.
- Amerigroup Iowa added the Chlamydia (CHL) measure to our value-based quality incentive program for Providers.

Postpartum Care (PPC)

- Amerigroup Iowa continues to provide educational resources to providers on CPT Category II coding education specific to Prenatal and Postpartum Care.
- Amerigroup Iowa continued with provider education to Primary Care and expanded to OB-GYN providers to improve the HEDIS rate such as a monthly provider resource email, HEDIS measure education, member resources and incentives, Gap in Care reports and supplemental EMR data exchanges.

- Amerigroup Iowa developed and implemented an educational webinar in 2022 on Prenatal and Postpartum Care for providers and clinical staff.
- Amerigroup Iowa continues to monitor denominator and numerator fluctuations through monthly HEDIS rates and monthly benchmark reports. A root cause analysis was initiated and reviewed with the HEDIS Task Force workgroup consisting of interdepartmental associates. We meet a minimum of monthly to discuss barriers, identify solutions and discuss outcomes.
- Amerigroup Iowa expanded our live telephonic member outreach to provide education on the importance of prenatal and postpartum care and assist members with scheduling their postpartum visits.
- Amerigroup Iowa initiated weekly Prenatal and Postpartum SMS text campaigns to eligible members.
- Amerigroup Iowa has a goal to improve the preterm birthrates among African American women. After analysis, it was determined that the preterm birth rate among black women is 32% higher in Iowa than among all other women. As a result, Amerigroup is currently focusing on several primary initiatives:
  - Leveraging an OB Practice Consultant to:
    - Increase provider collaboration and closure of HEDIS measures which support the goal
    - To educate and share informational information with providers
    - To increase referrals to case management and increase case management engagement
    - To educate providers on timely submission of the Maternal Notification of Pregnancy form and identify black/African American pregnant members via a monthly report that isn't currently auto-populating in the current case management system, so that OB case managers can outreach and engage these members.
  - Amerigroup Iowa initiated a doula program specific to African American pregnant women.
    - Elevance Health provided a $100,000 grant to the Iowa Black Doula Collective this year to provide recruitment and training for Black Doulas across Iowa- this effort helps to support health outcomes for Iowa black pregnant mothers and their infants.
    - Amerigroup Iowa is participating in the Department of Health and Human Services Title V Culturally Congruent, Community Based Doula Project for African American/ Black Identifying Birthing People by referring pregnant members who live in one of the following counties: Black Hawk, Dubuque, Polk, or Scott- if they are interested and give their consent for participation.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

- Amerigroup Iowa initiated provider education to prescribing provider types to improve the HEDIS rate such as a monthly provider resource email, HEDIS measure education, Gap in Care reports and supplemental EMR data exchanges.
- Amerigroup Iowa developed and implemented an educational webinar on Behavioral Health, including ADHD for providers and clinical staff.
- Amerigroup Iowa continues to monitor denominator and numerator fluctuations through monthly HEDIS rates and monthly benchmark reports. A root cause analysis was initiated and reviewed with the Behavioral Health HEDIS Task Force workgroup consisting of interdepartmental associates. We meet a minimum of monthly to discuss barriers, identify solutions and discuss outcomes.
- Amerigroup Iowa implemented member outreach mailings and IVR campaigns.

Mental Illnesses and Diabetes – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

- The Diabetes Screening for Schizophrenia or Bipolar Disorder Using Antipsychotic Meds (SSD-AD) measure was added to the Health Home Quality Incentive Program (HHQIP) for the 2021 performance measurement period.
- Amerigroup Iowa initiated provider education and expanded education to Behavioral Practitioners to provide focused education on metabolic monitoring to improve the HEDIS rates, a monthly Provider resource educational email, Gap in Care reports and supplemental EMR data exchanges.
- Amerigroup continues to monitor denominator and numerator fluctuations through monthly HEDIS rates and monthly benchmark reports. A root cause analysis was initiated and reviewed with the Behavioral Health HEDIS Task Force workgroup consisting of Interdepartmental associates. We meet a minimum of quarterly to discuss barriers, identify solutions and discuss outcomes.
- Amerigroup Iowa reviewed member educational resources and has developed a member-focused SMS (text) campaign.
- Amerigroup Iowa added SSD to our Behavioral Health (BH) value-based quality incentive program for Behavioral Health providers.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

HEDIS

Chlamydia Screening (CHL)

- Amerigroup Iowa's eligible population continued to increase YOY from 2017 to 2021, resulting in larger eligible population for this measure, and in our FINAL HEDIS CHL rate to show a slight improvement, yet continues to remain consistent at the Quality Compass 10th percentile.
  - HEDIS 2020 MY 2019 – 48.50 (10th percentile)
  - HEDIS 2021 MY 2020 – 44.86 (10th percentile)
  - HEDIS 2022 MY 2021 – 45.22 (10th percentile)

Postpartum Care (PPC)

- Based off total eligible population (administrative rates):
  - HEDIS 2020 MY2019: Postpartum Care – 34.95% (5th percentile)
  - HEDIS 2021 MY2020: Postpartum Care – 45.18% (5th percentile)
  - HEDIS 2021 MY2021: Postpartum Care – 45.94% (5th percentile)

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

- HEDIS 2020 MY2019 – 77.62% – (10th percentile)
- HEDIS 2021 MY2020 – 74.63% – (5th percentile)
- HEDIS 2022 MY2021 – 79.1% – (66th percentile)

Mental Illnesses and Diabetes – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

- HEDIS 2020 MY2019 – 77.62% – (10th percentile)
- HEDIS 2021 MY2020 – 74.63% – (5th percentile)
- HEDIS 2022 MY2021 – 79.1% – (66th percentile)

c. Identify any barriers to implementing initiatives:

HEDIS

Postpartum Care (PPC)

- Global Billing for prenatal and postpartum billing continues to be a barrier resulting in limited claims data that continues to affect our numerator compliance.
- Amerigroup Iowa identified a rural health barrier decrease in OB- GYNs compared to Urban areas.
- Telehealth visits were added to HEDIS MY2021 technical specifications and has allowed members other access to complete appointments. One barrier identified during the MY2021 Hybrid project was the member did not complete the visit with the appropriate provider type to meet numerator compliance.

HSAG Assessment: HSAG has determined that Amerigroup has addressed the prior recommendations and realized gains in performance on several measures; however, the MCO demonstrates ongoing opportunities for improvement on measures related to Women's Health and identified barriers related to access and billing. HSAG recommends that Amerigroup continue to focus on improvement strategies for those measures that continued to show low performance.

2. Prior Year Recommendation from the EQR Technical Report for Compliance Review:

HSAG recommended the following:

- In addition to developing a corrective action plan to mitigate the gaps within its processes and documentation, Amerigroup should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member information.
- In addition to developing a corrective action plan to mitigate the gaps within its processes and documentation, Amerigroup should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to ABD notice requirements.

MCP's Response

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

- Amerigroup reviews and updates the Member Handbook and Provider Directory on at least an annual basis and these recommendations have been taken into consideration. Recommendations regarding the Provider Directory have been shared with the corporate team.
- We have implemented quality reviews of our prior authorization determination letters and will continue to work to improve the quality and readability of the ABD notices.

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 Amerigroup has partially addressed the prior year recommendations related to member information. While Amerigroup indicated that it reviews and updates the Member Handbook and Provider Directory at least annually and has taken into consideration HSAG's recommendations, Amerigroup did not provide any specifics regarding whether the annual review of these member materials includes ensuring compliance with all federal and State obligations specific to member information. Additionally, while Amerigroup previously submitted a CAP during SFY 2021 to address the findings which resulted in HSAG's recommendations, the MCO did not provide any additional information on full implementation of its actions (i.e., automatically distributing member written materials in a member's

primary language; time frame for, and tracking of, provider termination notices; accessibility indicators in the provider directory; and dissemination of materials in a member's preferred mode of communication). HSAG continues to recommend that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations regarding member information.

HSAG has determined that Amerigroup has partially addressed the prior year recommendations related to adverse benefit determination (ABD) notice requirements. While the MCO implemented a quality review process to improve the quality and readability of ABD notices as recommended by HSAG through the CY 2021 compliance review CAP, the MCO did not provide any additional information on full implementation of its action plan related to mailings of ABD notices for a denial of payment at the time of any action affecting a claim. HSAG continues to recommend that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations regarding sending ABD notices.

3. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:

HSAG recommended the following:

- With the telehealth landscape constantly changing, Amerigroup should continue to monitor telehealth utilization to understand how members are accessing care. With increasing access to telehealth, the member experience may be changing as members have the option for in-person or telehealth visits. HSAG encourages Amerigroup to continue to monitor how access to telehealth may affect members and member outcomes over time. This information will allow Amerigroup to shape telehealth policies moving forward and ensure that all members have the ability to access the best healthcare options.

MCP's Response

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

- Amerigroup supports telehealth and have supported efforts for increased access to telehealth, particularly during the public health emergency. We do want to add additional telehealth providers to increase member access. We did see a decrease in telehealth claims received from 2020 to 2021.

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 Amerigroup has partially addressed the prior recommendations. While Amerigroup has indicated that it supported efforts for increased access to telehealth and noted a decrease in telehealth claims, the MCO did not provide additional details for HSAG to conduct a comprehensive assessment on the extent to which the MCO addressed the prior recommendations. Additionally, as telehealth was not part of this year's annual EQR, HSAG was unable to glean additional information on telehealth through this year's NAV activity.

4. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
HSAG recommended the following: **Calendar Year 2020—Medical Record Review** • Amerigroup should consider strengthening and/or enforcing its contract requirements with its providers to ensure that documentation and/or records are easily accessible, and providers respond in a timely manner when documentation and/or records are requested. • Amerigroup should consider performing periodic MRR of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews would then be shared with providers through periodic provider education and training regarding encounter data submission, medical record documentation, and coding practices. **Calendar Year 2021—Comparative Analysis** • Amerigroup should research the issue further and provide an explanation as to the differences in values from the different sources of data.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: **Medical Record Review** We have taken these recommendations for consideration as we continue to revise and improve our processes. **Comparative Analysis** • For Professional encounters, DHS identified a mapping rule resulting in an incorrect value being populated in the Rendering NPI field in the data warehouse. DHS implemented a change in August 2022 and Amerigroup Iowa will resubmit encounters to improve the surplus rate. • For Institutional encounters, Iowa Amerigroup made a mapping change for admission date to improve data the surplus rate. This should be evident on a prospective basis.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Medical Record Review** We are hopeful we will have improved performance in the current Medical Record Review being performed as part of the Encounter Data Validation. For our Annual HEDIS Hybrid project, we had a 90.7 percent retrieval rate. However, for ad hoc ongoing medical record review our response rate is lower, unless we have remote access to perform reviews. **Comparative Analysis** • Amerigroup is meeting contractual requirements for accuracy, completeness and timeliness and continues to improve data quality based on feedback from DHS and CMS T-MSIS.
c. Identify any barriers to implementing initiatives: Comparative Analysis

- 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 has not completely addressed the prior year recommendations regarding procuring requested medical records from its contracted providers. While Amerigroup noted that it will continue to revise and improve its current process, the current year medical record procurement rate was significantly lower than the prior year rate. As such, HSAG recommends that Amerigroup ensure its providers' accountability in responding to medical record requests for auditing, inspection, and oversight. Additionally, as recommended previously, Amerigroup should consider strengthening and/or enforcing contract requirements with its providers in supplying the requested documentation. HSAG has also determined that Amerigroup has addressed the prior year recommendations regarding issues noted related to data element discrepancies from the comparative analysis.

5. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

- Amerigroup should 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 recommended 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 and its contracted providers.
- Amerigroup should focus on initiatives through the MCO's QI program to provide medical assistance with smoking and tobacco use cessation and to develop efforts to promote a health education and wellness smoking cessation program.

MCP's Response

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

CAHPS:

Amerigroup continues to closely monitor the "Voice of the Customer" (post call member survey) results on a monthly basis to identify the source of dissatisfaction. If a deficiency is noted, a manager follows up with the member to get to the root of their issue and try to ensure member satisfaction. Those results are then brought to our quarterly Service Quality Committee for analysis and targeted action to improve results by dissatisfaction category.

In order to widely promote CAHPS results and solicit feedback from stakeholders, Amerigroup has made numerous efforts. Amerigroup presented the results of CAHPS to our Quality Management Committee and Medical Advisory Committee in addition to our Service Quality Committee and solicited feedback from all Stakeholders.

Amerigroup Iowa promoted an internal CAHPS training for staff for all of our member-facing staff. Amerigroup promoted the topic of CAHPS in the provider newsletter and promoted our CAHPS Training for providers in which they can get CEUs for attending. Amerigroup initiated a text campaign to members that is a post-provider text survey which allows us to gain more real-time data about member satisfaction in-between

CAHPS Surveys and target interventions accordingly. We also launched a CAHPS Proxy survey for members in the fall of 2021. In order to widely promote our results to members, we are also in the process of adding a document summarizing our most recent CAHPS results to our member website which will be updated annually.

Specific to transportation, Amerigroup is also working internally with our Call Center staff who have recently begun completing an informed transfer to our transportation vendor when the member needs to be transferred. This is a recently implemented intervention so we will continue to evaluate results on a monthly basis.

Amerigroup is also working to add the number for our transportation vendor on the member ID cards so that members have the number readily accessible and to cut down on phone calls and time spent for the member. Amerigroup is also working with our transportation vendor to ensure the vendor is properly training their staff to handle and address these calls as well. Through our work it has been learned that staff does not consistently understand where to look in the system to verify if the member has coverage.

Amerigroup has recently been working closely with our transportation vendor to ensure wait times and service levels not only increase but maintain an appropriate threshold.

Tobacco Cessation:

- Amerigroup has developed a text script to members to promote our tobacco cessation quit programming. This script is in the approval phase and will be launched to members upon approval. Amerigroup is also slated to promote our tobacco cessation programming to providers in our monthly Quality Management outreach to providers.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Through the results of our monthly "Voice of the Customer" survey, completed by Amerigroup's National Call Center, Amerigroup Iowa monitors the top reasons for dissatisfaction and metrics within those reasons for dissatisfaction such as if the inquiry was resolved during the call and if it was resolved on the first call, without having to transfer the member. Transportation remains the top reason for dissatisfaction. Overall, YOY the volume of complaints has decreased but remains a source of frustration for members. Over the last year, we have seen a slight increase in members feeling like their issues were resolved, going from Q3'21 results of 71.2% steadily climbing each quarter to a Q3'22 result of 79.2%. In addition, monitoring of our first call resolution score has improved each quarter YOY from a Q3'21 score of 47.0% to a Q3'22 score of 60.4%.
- Tobacco Cessation: TBD

c. Identify any barriers to implementing initiatives:

- None at this time.

HSAG Assessment: HSAG has determined that Amerigroup has partially addressed the prior year recommendations. HSAG recommends that Amerigroup continue to work on promoting its tobacco cessation programming to members and providers, as the 2022 scores for *Discussing Cessation Medications* and *Discussing Cessation Strategies* were statistically significantly lower than the 2021 NCQA adult Medicaid national averages.

Iowa Total Care, Inc.

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • Iowa Total Care should completely document its methods for collecting its data and how it generated its sample size for the eligible population. • Iowa Total Care should use appropriate QI tools to identify existing opportunities for improvement within its current processes. The results will support the MCO's approach for developing specific and targeted interventions to address the barriers identified.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Iowa Total Care included the methods for collecting data and how the sample size was generated from the eligible population by documenting data collection methods as outlined in the final CAHPS report provided by Iowa Total Care by its survey vendor, SPH Analytics. SPH provides CAHPS survey sampling frame size, margin of error, and confidence level for the final child CAHPS survey report. • Iowa Total Care used appropriate QI tools to identify existing opportunities for improvement by utilizing a fishbone analysis and stacked ranking list. The fishbone analysis identified reasons why an Iowa Total Care member may not receive the help they needed from customer service, and the stacked ranking identified opportunity areas for improvement initiatives based off staff and resource availability at Iowa Total Care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Iowa Total Care included the sampling frame size, margin of error, and confidence levels in its most recent PIP submission for both MY2020 and MY2021 • Both the fishbone analysis and stacked ranking documents were included in the most recent PIP submission
c. Identify any barriers to implementing initiatives: • No barriers were identified to implementing this initiative • No barriers were identified to implementing this initiative
HSAG Assessment: HSAG has determined that Iowa Total Care has addressed the prior recommendations. Within the most recent submission, the MCO accurately documented its methods for collecting data, used appropriate QI tools to identify existing barriers to care, and developed interventions to address those barriers.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: **PMV Results** • Iowa Total Care should consider providing limited system access in TruCare (e.g., user credentials are limited to only viewing and editing records for IHH members) to IHH clinical staff members for documenting care coordination and service plan data for performance measure reporting. This would potentially provide Iowa Total Care with efficiencies by preserving Iowa Total Care clinical staff time for clinical activities. It would also reduce the potential for errors in reporting. **HEDIS Results**

- Iowa Total Care should partner with primary care and obstetrics and gynecology (OB-GYN) providers to conduct a focused study to determine why some female members 16 to 24 years of age identified as sexually active were not getting screened for chlamydia and why some female members 21 to 64 years of age were not getting screened for cervical cancer. In addition, Iowa Total Care should conduct a focused study to determine why some female members were not receiving timely prenatal care. Upon identification of a root cause, Iowa Total Care should implement appropriate interventions (e.g., member incentives, promotion of telehealth services for prenatal care) to improve low performance rates within the Women's Health domain.
- Iowa Total Care should partner with providers such as community mental health centers that treat the severe and persistently mentally ill (SPMI) population to conduct a root cause analysis or focused study to determine why some members with severe mental illnesses are not being screened for diabetes or monitored for metabolic functioning. Upon identification of a root cause, Iowa Total Care should work with providers to implement appropriate interventions (e.g., process improvements, patient education campaign, provider incentives) to improve the performance rates of these measures.
- Iowa Total Care should partner with endocrine and primary care providers to conduct a root cause analysis or focused study to determine why some members with diabetes are not being tested regularly for their HbA1c level or having eye exams performed when recommended. Upon identification of a root cause, Iowa Total Care should work with providers to implement appropriate interventions (e.g., process improvements, patient education campaign, member or provider incentives) to improve the performance rates of these measures.

MCP's Response

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

PMV

- Iowa Total Care previously had given IHH staff access to enter care plans directly, however it was unsuccessful and increased the number of errors and abrasion with IHH partners. The auditing and manual entry by internal staff was implemented to mitigate this.

HEDIS

- Chlamydia (CHL) - We are conducting a deep dive into the CHL measure. Previous measure analysis indicated that 16–20 year-old females were not being tested at provider office visits. Education to all PCPs regarding the need for testing if on birth control as that is a determinant for denominator. Providers state that they are following USPSTF guidelines and screening members 16-21 for sexual activity and if they state no then they do not test. Birth control may be used for other reasons than just birth control
- SSD deep dive completed - providers may be ordering incorrect Lipid test to close the care gap. (ordering CMP and not a Cholesterol test) Provider education being completed in fall 2022.
- MY2020 was the first year of reporting CDC measures. In MY 2020 implemented home diabetic testing kit as well as a Retinal Eye fax form for providers to give to members to take to Eye Appt. When eye appointment is completed the eye Dr sends to Iowa Total Care and or the PCP

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV

- Issues with care plans can be addressed more quickly by internal IHH staff, there is less partner abrasion, and more accuracy in reporting measures.

HEDIS

- CHL rates have increased year over year MY 2020 - 45.60 MY 2021 48.61
- MY2020 (first year reporting) 73.50% My 2021 77.131%
- CDC EYE - MY2020 51.80% MY2021 - 59.37% CDC <8 - MY2020 38.90% MY2021 52.31%

c. Identify any barriers to implementing initiatives:

PMV

- Where ideally it would seem more efficient for IHH staff to enter care plans directly, due to the individualized plans and requirements of external IHH programs, entry by external IHH staff is not a reliable method at this point.

HEDIS

- Public Health does not require members to provide proof of insurance - hence we may not be receiving all the test results
- Lack of provider understanding of the correct test
- Covid was a barrier for members to get to the provider's office for testing - Home testing kits implemented

HSAG Assessment: HSAG has determined that Iowa Total Care has addressed the prior recommendations and realized gains in performance on several measures; however, the MCO demonstrates ongoing opportunities for improvement on measures related to Women's Health, Behavioral Health, and Medication Management. HSAG recommends that Iowa Total Care continue to focus on improvement strategies for those measures that continued to show low or declining performance.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:

HSAG recommended the following:

- In addition to developing a corrective action plan to mitigate the gaps within its processes and documentation, Iowa Total Care should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member information.
- In addition to developing a corrective action plan to mitigate the gaps within its processes and documentation, Iowa Total Care should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to ABD notice requirements.

MCP's Response

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

- Iowa Total Care has made the request to have the suggested language related to disenrollment's added to the Member Handbook. Iowa Total Care has updated the disenrollment letters to inform the member to contact DHS to continue their request to disenroll.
- Addressing consistently demonstrating ABD notices are sent timely: UM audits a minimum of 5 denials/month/nurse. Timely letters are part of the audit. Iowa Total Care UM runs a daily report of denial from the previous day and all cases are manually checked to verify both denial phones calls were made, and letters were sent timely. Iowa Total Care has engaged our IT team to develop systematic delivery of the noted ABD notice. Implementation timing will be dependent on discussions with Iowa Medicaid for implementation and alignment across the state. Iowa Total Care has engaged with Iowa Medicaid to align across the state to demonstrate an adequate process to ensure that members received an ABD notice for previously authorized services that were terminated, suspended, or reduced in accordance with federally required time frames.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Members are informed of the need to contact DHS to continue their request to disenroll.
- For untimely letters: Overall UM audit scores for 2022 are >99% across PA and CCR. An item on the audit is sending notification timely.

c. Identify any barriers to implementing initiatives:

- For timely ABD letters: Current documentation system does not have "real time" reporting - data "cuts" at 5pm to be in reports the following day. A new system is in development that will allow real time reports. Iowa Total Care estimate Go Live is late 2023/early 2024. Once on this new system it is hoped that real time reporting will assist with monitoring this throughout the day.

HSAG Assessment: HSAG has determined that Iowa Total Care has addressed the prior recommendations.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:

HSAG recommended the following:

- With the telehealth landscape constantly changing, Iowa Total Care should continue to monitor telehealth utilization to understand how members are accessing care. With increasing access to telehealth, the member experience may be changing as members have the option for in-person or telehealth visits. HSAG encourages Iowa Total Care to continue to monitor how access to telehealth may affect members and member outcomes over time. This information will allow Iowa Total Care to shape telehealth policies moving forward and ensure that all members have the ability to access the best healthcare options.

MCP's Response

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

- Iowa Total Care continues to educate members on our Telehealth Service offerings through our Member Newsletters, member website, Stakeholder Advisory Board meetings, and during applicable conversations with our member facing teams. We have recently implemented a Call Listening program which will allow us the opportunity to identify additional member opportunities.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Implemented a Call Listening Program

c. Identify any barriers to implementing initiatives:

- None

HSAG Assessment: HSAG has determined that Iowa Total Care has addressed the prior recommendations. However, telehealth was not part of this year's annual EQR; therefore, HSAG was unable to glean additional information on telehealth through this year's NAV activity.

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

HSAG recommended the following:

Calendar Year 2020—Administrative Profile Analysis

- Iowa Total Care should discuss the field(s) values with HHS to understand the root cause(s).

Calendar Year 2021—Comparative Analysis

- Iowa Total Care should implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced.

- Iowa Total Care should implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. Iowa Total Care noted that process modifications were underway to ensure diagnosis codes are reported correctly.
- HHS is aware of the DRG submission issue and is working with Iowa Total Care to remedy the issue. As such, Iowa Total Care should continue to work with HHS to ensure the issue has been corrected and that moving forward, the values are complete and accurate.

MCP's Response

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

Calendar Year 2020 - Administrative Profile Analysis

- Iowa Total Care did review field level details with DHS as part of our Encounter weekly review calls. Centene stores DRG values as 4 position fields. To account for this, a 3 position DRG code is stored with a leading 0. This was discussed with DHS, and we made a configuration change for Iowa to strip the leading zero at the time of encounter file creation, though master data will remain as 4 positions. This DRG variation would have impacted the overall DRG values at the time of the last audit.

Calendar Year 2021—Comparative Analysis

- The HSAG requirements document provided for the previous EDV does not explicitly address whether claims with an Iowa Total Care claim system status of void or claims with an encounters status of void should be included in the extract files. This was noted in Iowa Total Care's response but accounted for in future extracts.
- For vision claims, a logic change was made January 2022, to ensure our encounter files are generating with the correct diagnosis order.
- Logic was implemented that strips the leading zero during Encounter file creation. The database will still retain 4 positions to account for valid 4 position DRG values, but encounter file creation is accounted for now.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Calendar Year 2020 - Administrative Profile Analysis

- Change in encounter file creation leading to fewer invalid DRG codes.

Calendar Year 2021—Comparative Analysis

- Clarification of "voids" lead to simple change in extract. NEMT vendor recreated their files.
- Dx Codes in correct order now
- Change in encounter file creation leading to fewer invalid DRG codes.

c. Identify any barriers to implementing initiatives:

Calendar Year 2020 - Administrative Profile Analysis

- Given Centene stores DRG codes as 4 positions, this change was unique to Iowa and configured to strip the leading zero from encounter file creation.

Calendar Year 2021—Comparative Analysis

- None
- None

- Given Centene stores DRG codes as 4 positions, this change was unique to Iowa and configured to strip the leading zero from encounter file creation.

HSAG Assessment: HSAG has determined that Iowa Total Care has addressed the prior year recommendations.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

- While no weaknesses were identified, Iowa Total Care should continue to monitor the measures to ensure that there are no significant decreases in scores over time.

MCP's Response

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

Two new initiatives have begun in 2022 to monitor CAHPS survey weaknesses for Iowa Total Care:

1) Call listening program which QI staff will listen to member facing calls to identify areas of opportunity for improving the member experience.

2) Member and Provider Experience workgroup where staff from various departments at Iowa Total Care will meet to review member and provider survey results, identify areas of opportunity, and carry out action steps for improvement implementation projects.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

CAHPS Specialist will begin meeting with member-facing departments to review findings from the call listening program and identify areas of opportunity beginning in Q3. Additionally, the Member and Provider Experience Workgroup will begin meeting in Q3 and will review MY2021 CAHPS results during the kickoff meeting.

c. Identify any barriers to implementing initiatives:

No barriers were identified to implementing these initiatives.

HSAG Assessment: HSAG has determined that Iowa Total Care has addressed the prior year recommendations.

6. Follow-Up on Prior EQR Recommendations for PAHPs

From the findings of each PAHP's performance for the CY 2022 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 2021 External Quality Review Technical Report* are summarized in Table 6-1 and Table 6-2. The PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identifies performance improvement, and/or barriers identified are also provided in Table 6-1 and Table 6-2.

Delta Dental of Iowa

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • Delta Dental should revisit its causal/barrier analysis to determine and clearly document appropriate barriers. Delta Dental should establish a process for evaluating each intervention and its impact on the study indicators to allow for continual refinement of improvement strategies. • Delta Dental should develop active targeted interventions that can be tracked and trended to determine their impact on study indicator outcomes. The results should be used to guide decisions for QI efforts.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Delta Dental of Iowa completed a technical assistance call with Health Services Advisory Group in June 2022 to get recommendations on evaluation efforts to show clinical and program specific improvements. Additionally, Delta Dental discussed past interventions and how to make improvements for future targeted interventions to affect the study indicators identified for the programs. • The Delta Dental team has identified a set of internal health metrics as part of the standard procedure to evaluate program utilization on a continuous basis.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Delta Dental has completed and is utilizing member survey results to help understand barriers. The team is meeting monthly for quality improvement projects, including identifying new barriers to care activities for improvement.
c. Identify any barriers to implementing initiatives:
HSAG Assessment: HSAG has determined that Delta Dental has partially addressed the prior year recommendations. The PAHP revisited its causal/barrier analysis using health metrics to evaluate its program and member surveys to better understand member-specific barriers to care. However, the PAHP did not provide a response regarding the development of active and targeted interventions.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • Although no substantial weaknesses were identified in the calculation processes, to improve performance measure rates and the prevalence of dental care, Delta Dental should continue to implement performance improvement strategies that could positively impact the outcomes of the performance measures. • Delta Dental should meet with HHS as needed regarding encounter validation issues and work to resolve the rejections that are being caused by the billing provider Medicaid enrollment discrepancy.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Delta Dental is developing improvement activities that link to the performance measures and evaluating the effectiveness. • Delta Dental of Iowa has set up a bi-weekly meeting with the Department of Health and Human Services to address provider enrollment issues affecting encounter data validation.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Delta Dental has been able to work through issues on Iowa Medicaid provider enrollment applications resulting in 85% of the original rejected encounters being cleared.
c. Identify any barriers to implementing initiatives:
HSAG Assessment: HSAG has determined that Delta Dental has addressed the recommendations about partnering with HHS on addressing encounter issues, but Delta Dental did not provide any detail regarding improvement activities associated with increasing preventive dental care rates. Therefore, HSAG recommends that the PAHP continue to focus on preventive care initiatives and also ensure it is monitoring effectiveness for reporting in the following year.
3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • In addition to developing a corrective action plan to remediate deficiencies identified within the emergency and poststabilization processes, Delta Dental should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal regulations specific to emergency and poststabilization services.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Based on the policy clarification issued by Iowa Medicaid, Delta Dental has updated policies and procedures for emergency and poststabilization services. Claims identified as emergent have been included in the quality assurance review process that occurs monthly. Additional guidance on emergent and stabilization services was added to the Dental Wellness Plan Office Manual.
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 has partially addressed the prior year recommendations. While the PAHP indicated that it had updated policies and procedures and added additional

guidance on emergency and poststabilization services, Delta Dental did not provide any specifics regarding how the PAHP ensures compliance with all federal and State obligations. HSAG continues to recommend that the PAHP continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations regarding emergency and poststabilization services.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:

HSAG recommended the following:

- The results of the NAV analysis represent a snapshot of the provider network shortly after the transition of the DWP Kids members from FFS to the PAHP networks. Therefore, HSAG recommended continued monitoring of Delta Dental's provider network to assess member access to providers and changes to Delta Dental's provider network, as it may have contracted with additional providers to support the addition of DWP Kids members to their networks.

MCP's Response

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

- Delta Dental is monitoring provider networks on a monthly basis; strategies for recruitment are identified based on trends and patterns. This year our Dental Director conducted a Medicaid dental insurance educational session with undergraduate and graduate students at the University of Iowa Dental School and Creighton University Dental School.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- As part of recruitment efforts, Delta Dental of Iowa recruited three new graduates to the Dental Wellness Plan in July 2022.

c. Identify any barriers to implementing initiatives:

HSAG Assessment: HSAG has determined that Delta Dental has addressed the prior recommendations.

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

HSAG recommended the following:

- Delta Dental should work with HHS to determine if Delta Dental's submission dates within HHS' MMIS have been resolved and ensure that moving forward, the dates and other data elements are captured accurately.

MCP's Response

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

- Delta Dental worked with staff from the Department of Health and Human Services' Medicaid Management Information System to enhance internal reporting procedures.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

c. Identify any barriers to implementing initiatives:

HSAG Assessment: While HSAG has determined that Delta Dental has addressed the prior recommendation as it relates to submission dates, HSAG recommends that Delta Dental continue to work with MMIS staff to ensure other data elements are captured accurately.

Managed Care of North America Dental

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • MCNA Dental should revisit its causal/barrier analysis process and include challenges associated with the pandemic. Additional interventions, or modifications to the existing interventions, may be needed to mitigate the barriers associated with the pandemic.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • MCNA revisited the causal/barrier analysis and included challenges associated with the pandemic. The updates will be provided in the 10/14/22 PIP submission to HSAG.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
c. Identify any barriers to implementing initiatives: • MCNA has no barriers to report.
HSAG Assessment: HSAG has determined that MCNA Dental has addressed the prior year recommendation. The PAHP revisited its causal/barrier analysis process and addressed barriers linked to the pandemic.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • Although no substantial weaknesses were identified in the calculation processes, to improve performance measure rates and the prevalence of dental care, MCNA Dental should continue to implement performance improvement strategies that could positively impact the outcomes of the performance measures. • MCNA Dental should continue to work with HHS regarding encounter validation issues and work to resolve the rejections that are being caused by the billing provider Medicaid enrollment discrepancy.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • To further improve performance measure rates, MCNA has implemented targeted member and provider outreach campaigns that include an outbound call campaign to members identified with gaps in preventive care and an enhancement to our quarterly Practice Site Performance Summary (PSPS) provider reports that will showcase their sealant and fluoride utilization rates. • MCNA will continue to meet with Department of Health Services (DHS) staff related to encounter validation questions and resolutions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- These initiatives were recently implemented, and the improvement strategy outcomes are pending. However, MCNA will continue to monitor the performance measure rates to identify whether modifications and or additional improvement strategies are needed.

c. Identify any barriers to implementing initiatives:

- MCNA has no barriers to report.

HSAG Assessment: HSAG has determined that MCNA Dental has been addressing the recommendations, but MCNA Dental was unable to provide any information regarding the effectiveness of these initiatives. Therefore, HSAG recommends that the PAHP continue to focus on the initiatives and ensure it is monitoring effectiveness for reporting in the following year.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:

HSAG recommended the following:

- Although no significant weaknesses were identified, MCNA Dental should continually evaluate its processes, procedures, and monitoring efforts to ensure that it maintains compliance with all federal and State obligations.

MCP's Response

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

MCNA has ongoing monitoring and auditing activities that it conducts to assure that it maintains compliance with all federal and State obligations. Policies and procedures are evaluated on an annual basis to assure compliance with contract requirements and upon receipt of any contract amendments.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Not applicable

c. Identify any barriers to implementing initiatives:

Not applicable

HSAG Assessment: HSAG has determined that MCNA Dental has addressed the prior year recommendation.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:

HSAG recommended the following:

- The results of the NAV analysis represent a snapshot of the provider network shortly after the transition of the DWP Kids members from FFS to the PAHP networks. Therefore, HSAG recommended continued monitoring of MCNA Dental's provider network to assess member access to providers and changes to MCNA Dental's provider network, as it may have contracted with additional providers to support the addition of DWP Kids members to their networks.

MCP's Response

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

- MCNA's Network Development team has continued to recruit for additional providers during 2022 to ensure access to care and to support the addition of DWP Kids members to the DWP program. Recruitment efforts are on-going whereby non-contracted providers are contacted at least three times per year in an effort to increase the number of providers that participate in the network. The MCNA Network

Development team monitors network adequacy on a monthly basis and reports to the Quality Improvement Committee on a quarterly basis, using Network Adequacy Reports, Grievances related to network access, and Member and Provider Satisfaction Surveys to determine if there are any gaps to access for all DWP members.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- MCNA has increase the number of providers that participate in the network and these are providers that will be available to DWP Kid members. The addition of providers to the existing network in 2022 are as follows:
  - 53 General Dentists
  - 2 Oral and Maxillofacial Dentists
  - 5 Orthodontists
  - 6 Pediatric Dentists
  - 1 Periodontist
  - 2 Prosthodontists

c. Identify any barriers to implementing initiatives:

- MCNA continues to encounter challenges and/or barriers to recruiting additional General Dentists, 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. Limited number of general dentists in rural areas
  3. Low reimbursement – specialists believe that the fees are too low
  4. Providers believe that regulatory requirements are burdensome

HSAG Assessment: HSAG has determined that MCNA Dental has addressed the prior recommendations. HSAG recommends that MCNA Dental continue to address the recommendations around provider recruitment and building appropriate provider networks.

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

HSAG recommended the following:

- While no substantial weaknesses were identified, MCNA Dental should continually monitor its encounter submissions to HHS to ensure complete, accurate, and timely encounter data submissions.

MCP's Response

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

- MCNA will continue to meet with DHS staff related to encounter validation questions and resolutions. As part of the MCNA encounter submission process, we have implemented a report that lists all claims that were not able to be submitted as encounters along with reason. The report is reviewed by our Electronic Data Exchange (EDI) analyst who coordinates with any other necessary business unit to make necessary corrections to submit the encounter data by the following weekly submission cycle. Additionally, the EDI analyst has been equipped with monitoring dashboards that present encounter related performance metrics, such as percent acceptance and percent completion rates. These dashboards are also reviewed by management staff on a regular basis.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable
c. Identify any barriers to implementing initiatives: • MCNA has no barriers to report.
HSAG Assessment: While HSAG has determined that MCNA Dental has addressed the prior recommendations, HSAG recommends that MCNA Dental continue to work with HHS' MMIS staff and to monitor its encounter submissions to HHS to ensure complete, accurate, and timely encounter data submissions.

7. Managed Care Plan Comparative Information

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

External Quality Review Activity Results

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

Validation of Performance Improvement Projects

For the CY 2022 validation, the MCOs submitted Remeasurement 1 data for the two HHS-mandated PIP topics, and the PAHPs submitted baseline data for the HHS-mandated PIP topics. HSAG's validation evaluated the technical methods of the MCPs' PIPs (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of each MCP's PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, or *Not Met*).

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

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

MCP	Overall PIP Validation Status		Overall PIP Scores		
			Met	Partially Met	Not Met
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*	96%	0%	4%
ITC	*Timeliness of Postpartum Care*	*Met*	96%	4%	0%
ITC	*CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*	*Met*	96%	4%	0%
DDIA	*Annual Preventative Dental Visits*	*Partially Met*	82%	18%	0%
MCNA	*Increase the Percentage of Dental Services*	*Met*	100%	0%	0%

Performance Measure Validation

Table 7-2, Table 7-3, Table 7-4, and Table 7-5 show the reportable rates for the MCOs.

Table 7-2—SFY 2022 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	12.86%	50.80%	22.72%	9.20%	4.41%
ITC	3.60%	36.66%	20.40%	13.65%	25.69%

Table 7-3—SFY 2022 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	80.66%
ITC	92.87%

Table 7-4—SFY 2022 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*	1.69%	0.54%
2b	*Members With Documented Care Plan One-Time Service With Corresponding Approved Service Authorization*	33.33%	85.71%
2c	*Percentage of Authorized One-Time Services Utilized*	12.50%	66.67%

Table 7-5—SFY 2022 Performance Measure #3, #4, #5, and #6 Rates—MCO Comparison

Performance Measure		MCO	
		AGP	**ITC**
3	*Provision of Care Plan*	66.67%	94.47%
4	*Person-Centered Care Plan Meeting**	79.17%	97.31%
5	*Care Team Lead Chosen by the Member*	78.54%	99.59%
6	*Member Choice of HCBS Settings*	97.46%	98.78%

* 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.

Table 7-6 displays the HEDIS MY 2021 rates for the MCOs.

Table 7-6—SFY 2022 (MY 2021) HEDIS Rates—MCO Comparison

Measures	Amerigroup HEDIS MY 2021 Rate	Iowa Total Care HEDIS MY 2021 Rate	Statewide HEDIS MY 2021 Weighted Averages
Access to Preventive Care			
Adults' Access to Preventive/Ambulatory Health Services			
20–44 Years	79.78% ★★★★	78.84% ★★★	79.39% ★★★★
45–64 Years	85.53% ★★★	85.56% ★★★	85.54% ★★★
65 Years and Older	89.64% ★★★★	85.80% ★★★	86.30% ★★★
Use of Imaging Studies for Low Back Pain			
Use of Imaging Studies for Low Back Pain	70.49% ★	68.70% ★	69.74% ★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	71.78% ★★	72.02% ★★	71.86% ★★
Counseling for Nutrition—Total	64.96% ★★	61.80% ★★	63.89% ★★
Counseling for Physical Activity—Total	62.53% ★★	58.15% ★★	61.05% ★★
Women's Health			
Breast Cancer Screening			
Breast Cancer Screening	52.72% ★★	44.82% ★	48.92% ★★
Cervical Cancer Screening			
Cervical Cancer Screening	59.12% ★★★	55.72% ★★	57.68% ★★
Chlamydia Screening in Women			
Total	45.22% ★	48.67% ★★	46.54% ★
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.27% ★★★	0.50% ★★★	0.36% ★★★

Measures	Amerigroup HEDIS MY 2021 Rate	Iowa Total Care HEDIS MY 2021 Rate	Statewide HEDIS MY 2021 Weighted Averages
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	81.51% ★★	75.43% ★	78.87% ★
Postpartum Care	76.89% ★★★	76.40% ★★★	76.67% ★★★
Living With Illness			
Comprehensive Diabetes Care			
HbA1c Testing	88.32% ★★★★★	91.24% ★★★★★	89.69% ★★★★★
HbA1c Control (<8.0%)	48.42% ★★★	52.31% ★★★★	50.25% ★★★
*HbA1c Poor Control (>9.0%)**	42.34% ★★★	39.90% ★★★	41.19% ★★★
Blood Pressure Control (<140/90 mm Hg)	71.29% ★★★★★	69.34% ★★★★	70.37% ★★★★
Eye Exam (Retinal) Performed	54.99% ★★★	59.37% ★★★★	57.05% ★★★
Controlling High Blood Pressure			
Controlling High Blood Pressure	64.23% ★★★★	67.88% ★★★★★	65.91% ★★★★
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	80.24% ★★	62.03% ★	71.20% ★
Statin Therapy for Patients With Diabetes			
Received Statin Therapy	66.53% ★★★	50.19% ★	58.69% ★
Behavioral Health			
Diabetes Monitoring for People With Diabetes and Schizophrenia			
Diabetes Monitoring for People With Diabetes and Schizophrenia	72.32% ★★★★	55.15% ★	63.41% ★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.11% ★★★	77.13% ★★★	78.29% ★★★
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence			
7 Day Follow-Up—Total	50.53% ★★★★★	48.63% ★★★★★	49.66% ★★★★★

Measures	Amerigroup HEDIS MY 2021 Rate	Iowa Total Care HEDIS MY 2021 Rate	Statewide HEDIS MY 2021 Weighted Averages
30 Day Follow-Up—Total	56.33% ★★★★★	54.68% ★★★★★	55.58% ★★★★★
Follow-Up After ED Visit for Mental Illness			
7-Day Follow-Up—Total	67.10% ★★★★★	60.85% ★★★★	64.52% ★★★★★
30-Day Follow-Up—Total	77.99% ★★★★★	72.37% ★★★★	75.67% ★★★★★
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up—Total	57.61% ★★★★★	45.06% ★★★	52.37% ★★★★
30-Day Follow-Up—Total	75.50% ★★★★★	66.00% ★★★	71.53% ★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment			
Initiation of AOD Treatment—Total	74.64% ★★★★★	47.26% ★★★	62.35% ★★★★★
Engagement of AOD Treatment—Total	27.77% ★★★★★	16.87% ★★★	22.88% ★★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose and Cholesterol Testing–Total	24.68% ★	23.35% ★	24.26% ★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
Total	62.73% ★★	64.48% ★★★	63.32% ★★★
Keeping Kids Healthy			
Childhood Immunization Status			
Combination 3	73.24% ★★★★	71.05% ★★★	72.48% ★★★
Combination 10	49.15% ★★★★	44.04% ★★★	47.38% ★★★★
Immunizations for Adolescents			
Combination 1	85.89% ★★★	85.64% ★★★	85.80% ★★★
Combination 2	35.77% ★★	34.06% ★★	35.14% ★★
Lead Screening in Children			
Lead Screening in Children	77.62% ★★★	74.81% ★★★	76.64% ★★★

Measures	Amerigroup HEDIS MY 2021 Rate	Iowa Total Care HEDIS MY 2021 Rate	Statewide HEDIS MY 2021 Weighted Averages
Well-Child Visits in the First 30 Months of Life			
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	60.51% ★★★	51.47% ★★	56.45% ★★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	70.08% ★★	55.82% ★	65.67% ★
Child and Adolescent Well-Care Visits			
Total	49.75% ★★★	42.20% ★★	46.94% ★★★
Medication Management			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	64.67% ★★★	60.38% ★★	62.79% ★★
Antidepressant Medication Management			
Effective Acute Phase Treatment	60.15% ★★★	58.98% ★★★	59.65% ★★★
Effective Continuation Phase Treatment	42.52% ★★★	42.07% ★★★	42.33% ★★★
Appropriate Testing for Pharyngitis			
Total	78.09% ★★★	77.53% ★★★	77.87% ★★★
Appropriate Treatment for Upper Respiratory Infection			
Total	90.21% ★★★	90.99% ★★★	90.51% ★★★
Asthma Medication Ratio			
Total	70.27% ★★★	68.37% ★★★	69.59% ★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis			
Total	46.65% ★	51.10% ★★	48.52% ★★
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	43.41% ★★	42.28% ★★	43.02% ★★
Continuation and Maintenance Phase	47.83% ★★	50.11% ★★	48.56% ★★

Measures	Amerigroup HEDIS MY 2021 Rate	Iowa Total Care HEDIS MY 2021 Rate	Statewide HEDIS MY 2021 Weighted Averages
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	81.19% ★★	73.91% ★	77.72% ★★
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	72.33% ★★★	58.32% ★	65.64% ★★
Bronchodilator	81.67% ★★	67.19% ★	74.75% ★
Statin Therapy for Patients With Cardiovascular Disease			
Statin Adherence 80%—Total	69.30% ★★	67.32% ★★	68.44% ★★
Statin Therapy for Patients With Diabetes			
Statin Adherence 80%—Total	68.86% ★★★	65.87% ★★	67.63% ★★
Use of Opioids at High Dosage*			
Use of Opioids at High Dosage	2.07% ★★★★	1.72% ★★★★	1.92% ★★★★
Use of Opioids From Multiple Providers*			
Multiple Prescribers	18.27% ★★★	17.39% ★★★	17.90% ★★★
Multiple Pharmacies	1.07% ★★★★★	1.63% ★★★★	1.31% ★★★★
Multiple Prescribers and Multiple Pharmacies	0.81% ★★★★	1.20% ★★★	0.97% ★★★

* For this indicator, a lower rate indicates better performance.
HEDIS MY 2021 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

Delta Dental and MCNA Dental both received the rate designation of *Reportable* for all performance measures. Table 7-7 displays the DWP Adult rates for the PAHPs, and Table 7-8 displays the DWP Kids rates for the PAHPs.

Table 7-7—SFY 2022 Performance Measure Rates for DWP Adults—PAHP Comparison

Performance Measure		Measure Rates	
		DDIA	MCNA
2	*Members Who Accessed Dental Care*	29.09%	17.29%
3	*Members Who Received Preventive Dental Care*	71.93%	61.70%
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])*	59.69%	39.62%

* Performance measure #6 includes three distinct components.

Table 7-8—SFY 2022 Performance Measure Rates for DWP Kids—PAHP Comparison

Performance Measure		Measure Rates	
		DDIA	MCNA
3	*Members Who Received Preventive Dental Care*	47.20%	35.86%

Compliance Review

HSAG calculated overall performance for the Iowa Managed Care Program in each of the 14 compliance review standards that are reviewed as part of the three-year compliance review cycle. Table 7-9 compares the Iowa Managed Care Program average compliance score in each of the 14 standards with the compliance score achieved by each MCP.

Table 7-9—Summary of CY 2021 and CY 2022 Compliance Review Results

Standard	AGP	ITC	DDIA	MCNA	Iowa Managed Care Program
Standard I—Disenrollment: Requirements and Limitations	100%	71%	100%	100%	92%
Standard II—Member Rights and Member Information	80%	90%	82%	88%	85%
Standard III—Emergency and Poststabilization Services	100%	100%	70%	100%	93%
Standard IV—Availability of Services	100%	89%	100%	100%	97%

Standard	AGP	ITC	DDIA	MCNA	Iowa Managed Care Program
Standard V—Assurances of Adequate Capacity and Services	100%	100%	100%	100%	100%
Standard VI—Coordination and Continuity of Care	90%	100%	100%	86%	94%
Standard VII—Coverage and Authorization of Services	80%	80%	90%	100%	88%
Total Compliance Score for Year One (CY 2021)	**90%**	**90%**	**89%**	**95%**	**91%**
Standard VIII—Provider Selection	79%	86%	75%	100%	84%
Standard IX—Confidentiality	92%	100%	91%	100%	96%
Standard X—Grievance and Appeal Systems	87%	89%	84%	95%	89%
Standard XI—Subcontractual Relationships and Delegation	85%	100%	60%	60%	83%
Standard XII—Practice Guidelines	100%	100%	83%	100%	96%
Standard XIII—Health Information Systems[1]	100%	100%	85%	100%	95%
Standard XIV—Quality Assessment and Performance Improvement Program	93%	97%	88%	100%	95%
Total Compliance Score for Year Two (CY 2022)	**89%**	**94%**	**83%**	**96%**	**91%**
Combined Compliance Score for Year One (CY 2021) and Year Two (CY 2022)	**90%**	**93%**	**85%**	**95%**	**91%**

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 MCP's standards and for the Iowa Managed Care Program.
*Please use caution when reviewing the compliance scores across MCPs, as the results may not be comparable between MCOs and PAHPs.
[1] The Health Information Systems standard includes an assessment of each MCP's IS capabilities.

Network Adequacy Validation

Table 7-10, Table 7-11, Table 7-12, Table 7-13, Table 7-14, and Table 7-15 show provider ratios and the percentage of members with access to providers within the time/distance standards including stratified analyses of health equities by race/ethnicity, urbanicity, age, and a concentrated disadvantage index for Iowa Managed Care Program members.

Table 7-10—Provider Capacity Analysis for Medicaid Members

Provider Category	Number of Unique Providers	Provider-to-Member Ratio
Amerigroup—Medicaid		
Primary Care Provider		
Primary Care Provider—Adult	4,933	1:49
Primary Care Provider—Pediatric	3,842	1:47
Behavioral Health Provider		
Behavioral Health Provider, Inpatient	108	1:3,880
Behavioral Health Provider, Outpatient	3,662	1:115
Iowa Total Care—Medicaid		
Primary Care Provider		
Primary Care Provider—Adult	3,856	1:50
Primary Care Provider—Pediatric	3,420	1:40
Behavioral Health Provider		
Behavioral Health Provider, Inpatient	91	1:3,593
Behavioral Health Provider, Outpatient	3,602	1:91

Table 7-11—Provider Capacity Analysis for Hawki Members

Provider Category	Number of Unique Providers	Provider-to-Member Ratio
Amerigroup—Hawki		
Primary Care Provider		
Primary Care Provider—Pediatric	3,842	1:10
Behavioral Health Provider		
Behavioral Health Provider, Inpatient	108	1:337
Behavioral Health Provider, Outpatient	3,662	1:10
Iowa Total Care—Hawki		
Primary Care Provider		
Primary Care Provider—Pediatric	3,420	1:5
Behavioral Health Provider		
Behavioral Health Provider, Inpatient	91	1:165
Behavioral Health Provider, Outpatient	3,602	1:5

Table 7-12—Percentage of Members With Access to Adult PCPs Within Time/Distance Standards

Percentage of Members With Access to Adult Primary Care Providers Within the Time/Distance Standards (30 miles or 30 minutes)		
Stratification	**Amerigroup**	**Iowa Total Care**
	Medicaid	**Medicaid**
Urbanicity		
Urban	100.0%	100.0%
Rural	100.0%	100.0%
Concentrated Disadvantage Index		
No	100.0%	100.0%
Yes	100.0%	100.0%
Age Category		
19 to 64 years	100.0%	100.0%
65 and Older	100.0%	100.0%
Race/Ethnicity		
American Indian or Alaska Native	100.0%	100.0%
Asian	100.0%	100.0%
Black or African American	100.0%	100.0%
*Hispanic**	100.0%	100.0%
Two or More Races	100.0%	100.0%
Native Hawaiian and Other Pacific Islander	100.0%	100.0%
Unknown	100.0%	100.0%
White	100.0%	100.0%
Overall		
Overall	100.0%	100.0%

*Those identified as Hispanic can be of any race or combination of races. All other categories except Unknown are non-Hispanic.

Table 7-13—Percentage of Members With Access to Pediatric PCPs Within Time/Distance Standards

Percentage of Members With Access to Pediatric Primary Care Providers Within the Time/Distance Standards (30 miles or 30 minutes)				
Stratification	Amerigroup		Iowa Total Care	
	Medicaid	Hawki	Medicaid	Hawki
Urbanicity				
Urban	100.0%	100.0%	100.0%	100.0%
Rural	100.0%	100.0%	100.0%	100.0%
Concentrated Disadvantage Index				
No	100.0%	100.0%	100.0%	100.0%
Yes	100.0%	100.0%	100.0%	100.0%
Age Category				
18 and Under	100.0%	100.0%	100.0%	100.0%
Race				
American Indian or Alaska Native	100.0%	100.0%	100.0%	100.0%
Asian	100.0%	100.0%	100.0%	100.0%
Black or African American	100.0%	100.0%	100.0%	100.0%
*Hispanic**	100.0%	100.0%	100.0%	100.0%
Two or More Races	100.0%	100.0%	100.0%	100.0%
Native Hawaiian and Other Pacific Islander	100.0%	100.0%	100.0%	100.0%
Unknown	100.0%	100.0%	100.0%	100.0%
White	100.0%	100.0%	100.0%	100.0%
Overall				
Overall	100.0%	100.0%	100.0%	100.0%

*Those identified as Hispanic can be of any race or combination of races. All other categories except Unknown are non-Hispanic.

Table 7-14—Percentage of Members With Access to Behavioral Health Inpatient Providers Within Time/Distance Standards

Percentage of Members With Access to Behavioral Health Inpatient Providers Within the Time/Distance Standards				
Stratification	Amerigroup		Iowa Total Care	
	Medicaid	Hawki	Medicaid	Hawki
Urbanicity				
Urban	100.0%	100.0%	100.0%	100.0%
Rural	100.0%	100.0%	100.0%	100.0%
Concentrated Disadvantage Index				
No	100.0%	100.0%	100.0%	100.0%
Yes	100.0%	100.0%	100.0%	100.0%
Age Category				
18 and Under	100.0%	100.0%	100.0%	100.0%
19 to 64 years	100.0%	NA	100.0%	NA
65 and Older	100.0%	NA	100.0%	NA
Race				
American Indian or Alaska Native	100.0%	100.0%	100.0%	100.0%
Asian	100.0%	100.0%	100.0%	100.0%
Black or African American	100.0%	100.0%	100.0%	100.0%
*Hispanic**	100.0%	100.0%	100.0%	100.0%
Two or More Races	100.0%	100.0%	100.0%	100.0%
Native Hawaiian and Other Pacific Islander	100.0%	100.0%	100.0%	100.0%
Unknown	100.0%	100.0%	100.0%	100.0%
White	100.0%	100.0%	100.0%	100.0%
Overall				
Overall	100.0%	100.0%	100.0%	100.0%

*Those identified as Hispanic can be of any race or combination of races. All other categories except Unknown are non-Hispanic.

Table 7-15—Percentage of Members With Access to Behavioral Health Outpatient BH Providers Within Time/Distance Standards

Percentage of Members With Access to Behavioral Health Outpatient Providers Within the Time/Distance Standards (30 miles or 30 minutes)				
Stratification	**Amerigroup**		**Iowa Total Care**	
	Medicaid	**Hawki**	**Medicaid**	**Hawki**
Urbanicity				
Urban	100.0%	100.0%	>99.9%	>99.9%
Rural	100.0%	100.0%	99.6%	99.5%
Concentrated Disadvantage Index				
No	100.0%	100.0%	99.7%	99.6%
Yes	100.0%	100.0%	>99.9%	99.9%
Age Category				
18 and Under	100.0%	100.0%	99.8%	99.7%
19 to 64 years	100.0%	NA	99.8%	NA
65 and Older	100.0%	NA	99.7%	NA
Race				
American Indian or Alaska Native	100.0%	100.0%	99.5%	98.0%
Asian	100.0%	100.0%	>99.9%	100.0%
Black or African American	100.0%	100.0%	>99.9%	100.0%
*Hispanic**	100.0%	100.0%	>99.9%	100.0%
Two or More Races	100.0%	100.0%	99.9%	99.3%
Native Hawaiian and Other Pacific Islander	100.0%	100.0%	>99.9%	100.0%
Unknown	100.0%	100.0%	99.8%	99.8%
White	100.0%	100.0%	99.8%	99.7%
Overall				
Overall	100.0%	100.0%	99.8%	99.7%

*Those identified as Hispanic can be of any race or combination of races. All other categories with the exception of Unknown are non-Hispanic.

Table 7-16 shows the percentage of DWP, DWP Kids, and Hawki members with access to general dentists within the time/distance access standards.

Table 7-16—Percentage of Members With Access to General Dentists Within the Time/Distance Standards

PAHP	Percentage of Members With Access to General Dentists Within the Time/Distance Standards			
	Full Network[1]		Active Network[2]	
	Rural (60 miles or 60 minutes)	Urban (30 miles or 30 minutes)	Rural (60 miles or 60 minutes)	Urban (30 miles or 30 minutes)
DDIA				
DWP	100.0%	100.0%	100.0%	100.0%
DWP Kids	100.0%	100.0%	100.0%	100.0%
Hawki	100.0%	100.0%	100.0%	100.0%
MCNA				
DWP	100.0%	99.9%	100.0%	99.9%
DWP Kids	100.0%	99.9%	100.0%	99.9%

[1] Full network includes all providers submitted who were eligible for inclusion in the Dental Provider Network Analysis.
[2] Active network is restricted to those full network providers who have seen at least five members in the past 12 months and otherwise meet the inclusion criteria for the Dental Provider Network Analysis.

Encounter Data Validation

Medical Record Review—MCO

Table 7-17 presents the percentage of medical record documentation submissions, and Table 7-18 presents the major reasons medical record documentation was not submitted by each MCO.

Table 7-17—Summary of Medical Records Requested and Received by MCO

MCO	Number of Records Requested	Records Submitted		Records Submitted With Second Date of Service	
		Number	Percent[1]	Number	Percent[2]
Amerigroup	411	230	56.0%	123	53.5%
Iowa Total Care	411	389	94.6%	368	94.6%
All MCOs	**822**	**619**	**75.3%**	**491**	**79.3%**

[1] Percent was calculated based on number of records requested and number of records submitted.
[2] Percent was calculated based on number of records submitted and number of records submitted with second date of service.

Table 7-18—Reasons Medical Records Not Submitted for Date of Service by MCO

Key Data Elements	Medical Record Omission[1]			Encounter Data Omission[2]		
	Overall	AGP	ITC	Overall	AGP	ITC
Date of Service	**25.4%**	39.5%	4.5%	**5.2%**	7.9%	1.3%
Diagnosis Code	**28.4%**	42.5%	7.4%	**2.6%**	3.9%	0.7%
Procedure Code	**27.9%**	38.3%	12.2%	**5.2%**	6.7%	3.0%
Procedure Code Modifier	**35.2%**	48.3%	15.7%	**5.7%**	5.4%	6.2%

[1] Services documented in the encounter data but not supported by the members' medical records. Lower rate values indicate better performance.
[2] Services documented in the members' medical records but not in the encounter data. Lower rate values indicate better performance.

Table 7-19 displays the element accuracy rates for each key data element and the all-element accuracy rates.

Table 7-19—Encounter Data Accuracy Summary by MCO

Data Element	Statewide	AGP	ITC	Statewide Inaccuracy Reasons
Diagnosis Code	**99.9%**	100.0%	99.8%	1. Inaccurate Code (66.7%) 2. Specificity Error[1] (33.3%)
Procedure Code	**97.2%**	96.8%	97.9%	1. Inaccurate Code (100.0%) 2. Higher Level of Service in Medical Record (0.0%) 3. Lower Level of Service in Medical Record (0.0%)
Procedure Code Modifier	**99.7%**	100.0%	99.3%	—
All-Element Accuracy[2]	**80.0%**	81.1%	78.2%	—

"—" Denotes that the error type analysis was not applicable to a given data element.
[1] Specificity errors occurred when the documentation supported a more specific code than was listed in HHS' encounter data. Specificity errors also include diagnosis codes that do not have the required fourth or fifth digit.
[2] The all-element accuracy rate describes the percentage of dates of service present in both HHS' encounter data and in the medical records with all data elements coded correctly (i.e., not omitted from the medical record; not omitted from the encounter data; and, when populated, have the same values).

Comparative Analysis—MCO

Table 7-20 displays the percentage of records present in the files submitted by the MCOs that were not found in the HHS-submitted files (record omission), and the percentage of records present in the HHS-submitted files but not present in the MCO-submitted files (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 7-20—Record Omission and Surplus Rates by MCO and Encounter Type

MCO	Professional Encounters		Institutional Encounters		Pharmacy Encounters	
	Omission	Surplus	Omission	Surplus	Omission	Surplus
Amerigroup	4.2%	1.0%	2.0%	0.6%	0.4%	1.8%
Iowa Total Care	7.7%	4.5%	19.7%	<0.1%	0.4%	<0.1%
Overall	**5.6%**	**2.4%**	**9.4%**	**0.4%**	**0.4%**	**1.0%**

Table 7-21 displays the element omission, element surplus, and element absent results for each key data element from the professional encounters. For the element omission and surplus indicators, lower rates indicate better performance. However, for the element absent indicator, neither lower nor higher rates indicate better or worse performance.

Table 7-21—Data Element Omission, Surplus, and Absent: Professional Encounters

Key Data Element*	Element Omission			Element Surplus			Element Absent		
	Overall	AGP	ITC	Overall	AGP	ITC	Overall	AGP	ITC
Member ID	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Detail Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Detail Service To Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Billing Provider NPI	**0.0%**	0.0%	0.0%	**1.4%**	<0.1%	3.6%	**<0.1%**	0.0%	<0.1%
Rendering Provider NPI	**0.0%**	0.0%	0.0%	**16.1%**	<0.1%	41.4%	**<0.1%**	0.0%	<0.1%
Referring Provider NPI[1]	**0.8%**	<0.1%	2.1%	**0.8%**	1.3%	0.0%	**60.2%**	61.8%	57.7%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Secondary Diagnosis Code[1]	**0.0%**	0.0%	0.0%	**4.5%**	0.0%	11.6%	**53.2%**	54.5%	51.3%
Procedure Code (CDT/CPT/HCPCS)	**0.0%**	0.0%	0.0%	**<0.1%**	0.0%	<0.1%	**0.0%**	0.0%	0.0%
Procedure Code Modifier[1]	**<0.1%**	0.0%	<0.1%	**<0.1%**	0.0%	<0.1%	**54.1%**	52.8%	56.1%
Units of Service	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
NDC[1]	**<0.1%**	0.0%	<0.1%	**0.0%**	0.0%	0.0%	**94.3%**	94.8%	93.5%
Detail Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%

* NPI = National Provider Identifier; CDT = Current Dental Terminology; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code

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

Table 7-22 displays the element omission, element surplus, and element absent results for each key data element from the institutional encounters. For the element omission and element surplus indicators,

lower rates indicate better performance. However, for the element absent indicator, neither lower nor higher rates indicate better or worse performance.

Table 7-22—Data Element Omission, Surplus, and Absent: Institutional Encounters

Key Data Element*	Element Omission			Element Surplus			Element Absent		
	Overall	AGP	ITC	Overall	AGP	ITC	Overall	AGP	ITC
Member ID	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Header Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Header Service To Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Admission Date[1]	**0.0%**	0.0%	0.0%	**<0.1%**	0.0%	<0.1%	**78.5%**	80.0%	76.1%
Billing Provider NPI	**0.0%**	0.0%	0.0%	**<0.1%**	0.0%	<0.1%	**0.0%**	0.0%	0.0%
Attending Provider NPI	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.2%**	<0.1%	0.5%
Referring Provider NPI[1]	**<0.1%**	0.0%	<0.1%	**<0.1%**	0.0%	0.1%	**96.3%**	96.3%	96.3%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Secondary Diagnosis Code[1]	**<0.1%**	0.0%	<0.1%	**<0.1%**	0.0%	<0.1%	**16.8%**	17.1%	16.2%
Procedure Code (CDT/CPT/HCPCS)[1]	**0.1%**	0.1%	0.1%	**0.1%**	0.0%	0.2%	**16.3%**	15.4%	17.9%
Procedure Code Modifier[1]	**0.2%**	0.0%	0.5%	**0.2%**	0.0%	0.5%	**75.5%**	75.5%	75.5%
Units of Service	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Primary Surgical Procedure Code[1]	**0.9%**	0.7%	1.2%	**0.2%**	0.4%	0.0%	**94.6%**	95.3%	93.3%
Secondary Surgical Procedure Code[1]	**0.6%**	0.5%	0.8%	**0.2%**	0.3%	0.0%	**96.5%**	96.9%	95.6%
NDC[1]	**0.2%**	0.0%	0.5%	**0.1%**	0.0%	0.2%	**89.1%**	89.0%	89.4%
Revenue Code	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
DRG Code[1]	**<0.1%**	<0.1%	0.0%	**<0.1%**	0.0%	<0.1%	**91.4%**	92.4%	89.7%
Header Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Detail Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%

* NPI = National Provider Identifier; CDT = Current Dental Terminology; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code; DRG = Diagnosis Related Group

[1] *Admission Date*, *Referring Provider NPI*, *Secondary Diagnosis Code*, *Procedure Code (CDT/CPT/HCPCS)*, *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 encounter transaction).

Table 7-23 displays the element omission, element surplus, and element absent results for each key data element from the pharmacy encounters. For the element omission and element surplus indicators, lower rates indicate better performance. However, for the element absent indicator, neither lower nor higher rates indicate better or worse performance.

Table 7-23—Data Element Omission, Surplus, and Absent: Pharmacy Encounters

Key Data Element*	Element Omission			Element Surplus			Element Absent		
	Overall	AGP	ITC	Overall	AGP	ITC	Overall	AGP	ITC
Member ID	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Header Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Billing Provider NPI	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Prescribing Provider NPI	**0.0%**	0.0%	0.0%	**<0.1%**	0.1%	0.0%	**0.0%**	0.0%	0.0%
NDC	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Drug Quantity	**0.1%**	0.1%	0.1%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Header Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Dispensing Fee	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%

* NPI = National Provider Identifier; NDC = National Drug Code

Table 7-24 displays the percentage of records with the same values (i.e., element accuracy) in the MCO-submitted files and the HHS-submitted files for each key data element associated with the professional, institutional, and pharmacy encounters. For the element accuracy indicator, higher rates indicate better performance.

Table 7-24—Data Element Accuracy: Professional, Institutional, and Pharmacy Encounters

Key Data Element*	Professional			Institutional			Pharmacy		
	Overall	AGP	ITC	Overall	AGP	ITC	Overall	AGP	ITC
Member ID	**>99.9%**	100.0%	>99.9%	**>99.9%**	>99.9%	>99.9%	**>99.9%**	>99.9%	>99.9%
Header Service From Date				**>99.9%**	100.0%	>99.9%	**100.0%**	100.0%	100.0%
Header Service To Date				**>99.9%**	100.0%	>99.9%			
Admission Date				**>99.9%**	>99.9%	>99.9%			
Detail Service From Date	**>99.9%**	>99.9%	>99.9%						
Detail Service To Date	**98.4%**	97.3%	>99.9%						
Billing Provider NPI	**99.8%**	>99.9%	99.7%	**>99.9%**	>99.9%	>99.9%	**99.9%**	>99.9%	99.9%

Key Data Element*	Professional			Institutional			Pharmacy		
	Overall	AGP	ITC	Overall	AGP	ITC	Overall	AGP	ITC
Attending Provider NPI				**100.0%**	100.0%	100.0%			
Rendering Provider NPI	**99.8%**	99.7%	100.0%						
Referring Provider NPI	**>99.9%**	100.0%	>99.9%	**100.0%**	100.0%	100.0%			
Prescribing Provider NPI							**>99.9%**	>99.9%	100.0%
Primary Diagnosis Code	**97.2%**	100.0%	92.8%	**>99.9%**	100.0%	>99.9%			
Secondary Diagnosis Code	**97.5%**	100.0%	92.6%	**>99.9%**	100.0%	>99.9%			
Procedure Code (CDT/CPT/HCPCS)	**>99.9%**	100.0%	>99.9%	**98.9%**	100.0%	96.9%			
Procedure Code Modifier	**>99.9%**	100.0%	>99.9%	**99.7%**	100.0%	99.2%			
Units of Service	**87.4%**	79.6%	99.6%	**65.1%**	48.4%	93.3%			
Primary Surgical Procedure Code				**100.0%**	100.0%	100.0%			
Secondary Surgical Procedure Code				**99.8%**	99.9%	99.8%			
NDC	**100.0%**	100.0%	100.0%	**96.9%**	100.0%	91.0%	**99.8%**	99.8%	99.8%
Revenue Code				**99.3%**	99.9%	98.2%			
DRG Code				**99.5%**	99.2%	99.9%			
Drug Quantity							**98.0%**	99.4%	96.1%
Header Paid Amount				**96.1%**	96.1%	96.1%	**100.0%**	100.0%	100.0%
Detail Paid Amount	**95.3%**	92.6%	99.7%	**98.0%**	97.9%	98.1%			
Dispensing Fee							**100.0%**	100.0%	100.0%

* NPI = National Provider Identifier; CDT = Current Dental Terminology; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code; DRG = Diagnosis Related Group
Gray cells indicate that the data elements were not evaluated for certain encounter types.

Table 7-25 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing or non-missing) for all key data elements relevant to each encounter data type.

Table 7-25—All-Element Accuracy by MCO and Encounter Type

MCO	Professional Encounters	Institutional Encounters	Pharmacy Encounters
AGP	69.7%	45.6%	99.0%
ITC	79.3%	87.7%	95.7%
Overall	**73.4%**	**61.3%**	**97.6%**

Comparative Analysis—PAHP

Table 7-26 displays the percentage of records present in the files submitted by the PAHPs that were not found in the HHS-submitted files (record omission), and the percentage of records present in the HHS-submitted files but not present in the PAHP-submitted files (record surplus). **Lower rates indicate better performance for both record omission and record surplus**.

Table 7-26—Dental Record Omission and Surplus Rates: By PAHP

PAHP	Record Omission	Record Surplus
DDIA	1.2%	0.8%
MCNA	8.2%	3.4%
Overall[1]	**2.5%**	**1.3%**

[1] The overall calculation was based on combined results for Delta Dental and MCNA Dental. Since Delta Dental had a significantly higher volume of encounters compared to MCNA Dental, the overall rates were highly affected by the proportion of Delta Dental's encounters.

Table 7-27 displays the element omission, element surplus, and element absent results for each key data element from the dental encounters. **For the element omission and surplus indicators, lower rates indicate better performance**. However, for the element absent indicator, neither lower nor higher rates indicate better or worse performance

Table 7-27—Data Element Omission, Surplus, and Absent: By PAHP

Key Data Element	Element Omission			Element Surplus			Element Absent		
	Overall Rate	DDIA	MCNA	Overall Rate	DDIA	MCNA	Overall Rate	DDIA	MCNA
Member ID	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Header Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Header Service To Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Detail Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Detail Service To Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Billing Provider NPI	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%

Key Data Element	Element Omission			Element Surplus			Element Absent		
	Overall Rate	DDIA	MCNA	Overall Rate	DDIA	MCNA	Overall Rate	DDIA	MCNA
Rendering Provider NPI	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
CDT Code	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Units of Service	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Tooth Number	**1.1%**	<0.1%	5.8%	**0.1%**	<0.1%	0.3%	**72.5%**	75.3%	59.5%
Tooth Surface 1	**9.2%**	11.2%	0.2%	**<0.1%**	0.0%	0.2%	**88.7%**	88.8%	88.3%
Tooth Surface 2	**6.1%**	7.5%	0.2%	**<0.1%**	0.0%	0.1%	**92.4%**	92.5%	91.8%
Tooth Surface 3	**2.3%**	2.8%	0.1%	**<0.1%**	0.0%	0.1%	**97.0%**	97.2%	96.4%
Tooth Surface 4	**0.7%**	0.8%	<0.1%	**<0.1%**	0.0%	<0.1%	**99.1%**	99.2%	98.9%
Tooth Surface 5	**0.1%**	0.1%	<0.1%	**<0.1%**	0.0%	<0.1%	**99.9%**	99.9%	99.8%
Oral Cavity Code 1	**6.7%**	<0.1%	36.9%	**0.2%**	<0.1%	0.8%	**90.9%**	97.7%	60.3%
Oral Cavity Code 2	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**100.0%**	100.0%	100.0%
Oral Cavity Code 3	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**100.0%**	100.0%	100.0%
Oral Cavity Code 4	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**100.0%**	100.0%	100.0%
Oral Cavity Code 5	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**100.0%**	100.0%	100.0%
Detail Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Header Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%

Table 7-28 displays the percentage of records with the same values in each PAHP's submitted files and HHS' submitted files for each key data element associated with the dental encounters. For this indicator, higher rates indicate better performance.

Table 7-28—Data Element Accuracy: By PAHP

Key Data Element	Element Accuracy		
	Overall Rate	DDIA	MCNA
Member ID	**>99.9%**	>99.9%	100.0%
Header Service From Date	**99.9%**	>99.9%	99.7%
Header Service To Date	**99.9%**	>99.9%	99.7%
Detail Service From Date	**99.7%**	99.7%	99.9%
Detail Service To Date	**99.7%**	99.7%	99.9%
Billing Provider NPI	**97.5%**	97.6%	97.1%

Key Data Element	Element Accuracy		
	Overall Rate	DDIA	MCNA
Rendering Provider NPI	**>99.9%**	>99.9%	100.0%
CDT Code	**99.2%**	99.8%	96.7%
Units of Service	**99.9%**	>99.9%	99.7%
Tooth Number	**99.3%**	99.9%	97.5%
Tooth Surface 1	**58.4%**	NA	58.4%
Tooth Surface 2	**41.9%**	NA	41.9%
Tooth Surface 3	**14.2%**	NA	14.2%
Tooth Surface 4	**12.7%**	NA	12.7%
Tooth Surface 5	**1.1%**	NA	1.1%
Oral Cavity Code 1	**75.4%**	89.9%	1.3%
Oral Cavity Code 2	**NA**	NA	NA
Oral Cavity Code 3	**NA**	NA	NA
Oral Cavity Code 4	**NA**	NA	NA
Oral Cavity Code 5	**NA**	NA	NA
Detail Paid Amount	**98.4%**	98.8%	96.3%
Header Paid Amount	**99.4%**	>99.9%	96.7%

NA indicates that there were no matched records for that data element.

Consumer Assessment of Healthcare Providers and Systems Analysis

HSAG compared each MCO's and the MCO program's (i.e., Amerigroup and Iowa Total Care combined) results to the 2021 NCQA national averages to determine if the results were statistically significantly higher or lower than the 2021 NCQA national averages. Arrows in the tables note statistical significance. A green upward arrow (↑) indicates a top-box score that was statistically significantly higher than the 2021 NCQA national average. Conversely, a red downward arrow (↓) indicates a top-box score that was statistically significantly lower than the 2021 NCQA national average. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as NA.

Table 7-29 and Table 7-30 present the 2022 top-box scores for Amerigroup and Iowa Total Care compared to the top-box scores of the MCO program for the adult and child Medicaid populations, respectively.

Table 7-29—2022 MCO Adult CAHPS Comparisons

	AGP	ITC	MCO Program
Composite Measures			
Getting Needed Care	86.0% ↑	86.5%	86.2% ↑
Getting Care Quickly	85.8% ↑	NA	86.7% ↑
How Well Doctors Communicate	93.7%	92.2%	93.1%
Customer Service	NA	NA	92.3%
Global Ratings			
Rating of All Health Care	55.1%	61.4%	57.6%
Rating of Personal Doctor	70.6%	70.2%	70.5%
Rating of Specialist Seen Most Often	67.1%	NA	67.9%
Rating of Health Plan	61.1%	60.3%	60.8%
Effectiveness of Care Measures*			
Advising Smokers and Tobacco Users to Quit	69.3%	73.3%	71.0%
Discussing Cessation Medications	42.6% ↓	53.1%	47.1%
Discussing Cessation Strategies	38.2% ↓	47.2%	42.0%

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

↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.

↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Table 7-30—2022 MCO Child CAHPS Comparisons[7-1]

	AGP	ITC	MCO Program
Composite Measures			
Getting Needed Care	90.1% ↑	86.1%	88.1% ↑
Getting Care Quickly	91.7% ↑	89.9% ↑	90.7% ↑
How Well Doctors Communicate	96.5% ↑	95.2%	95.8% ↑
Customer Service	NA	85.6%	89.1%

[7-1] Since ITC administered the CAHPS 5.1H Child Medicaid Health Plan Survey without the CCC measurement set, HSAG cannot perform MCO comparisons for the CCC composite measures/items. Therefore, these measures are not included in the table.

	AGP	ITC	MCO Program
Global Ratings			
Rating of All Health Care	74.1%	76.5% ↑	75.3% ↑
Rating of Personal Doctor	82.5% ↑	81.1% ↑	81.8% ↑
Rating of Specialist Seen Most Often	76.5%	78.0%	77.3%
Rating of Health Plan	73.6%	73.0%	73.3%

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."
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Scorecard

HHS contracted with HSAG in 2022 to develop a scorecard to evaluate the performance of Iowa Medicaid MCOs. The Iowa Medicaid scorecard demonstrates how the MCOs compare to national benchmarks in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 7-31. Please refer to Appendix A for the detailed methodology used for this tool.

Table 7-31—Iowa Medicaid Scorecard Results—MCO Scorecard Performance Ratings

Rating	MCO Performance Compared to National Benchmarks	
★★★★★	**Highest Performance**	The MCO's average performance was at or above the national Medicaid 90th percentile
★★★★	**High Performance**	The MCO's average performance was between the national Medicaid 75th and 89th percentiles
★★★	**Average Performance**	The MCO's average performance was between the national Medicaid 50th and 74th percentiles
★★	**Low Performance**	The MCO's average performance was between the national Medicaid 25th and 49th percentiles
★	**Lowest Performance**	The MCO's average performance was below the national Medicaid 25th percentile

Table 7-32 displays the 2022 Iowa Medicaid Scorecard results for each MCO.

Table 7-32—2022 Iowa Medicaid Scorecard Results

MCO	Doctors' Communication and Patient Engagement	Access to Preventive Care	Women's Health	Living With Illness	Behavioral Health	Medication Management
AGP	★★★	★★★★	★★★	★★★	★★★★	★★★
ITC	★★★	★★★	★★	★★★	★★★	★★★

For 2022, Amerigroup demonstrated the strongest performance by achieving High Performance for two of the six reporting categories (*Access to Preventive Care* and *Behavioral Health*) and Average Performance for four of the six reporting categories (*Doctors' Communication and Patient Engagement, Women's Health, Living With Illness,* and *Medication Management*). Iowa Total Care demonstrated average performance by achieving Average Performance for five of the six reporting categories (*Doctors' Communication and Patient Engagement, Access to Preventive Care, Living With Illness, Behavioral Health,* and *Medication Management*) and Low Performance for one of the six reporting categories (*Women's Health*). Opportunities for improvement exist, with both MCOs having Average Performance in at least four of the reporting categories and Iowa Total Care having a Low Performance rating in one reporting category.

8. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the MCPs' performance and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the Iowa Medicaid Managed Care Program to identify programwide conclusions. HSAG presents these programwide conclusions and corresponding recommendations to HHS to drive progress toward achieving the goals of the Quality Strategy and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members.

As HHS maintains separate quality strategies for the MCOs and PAHPs, the overarching goals (Behavioral Health, Access to Care, etc.) identified in the MCO Quality Strategy are not included in the PAHP Quality Strategy. However, to conduct a comprehensive assessment of programwide conclusions inclusive of all services covered under the Iowa Managed Care Program (i.e., MCOs and PAHPs), HSAG included PAHP-specific conclusions under the overarching goals of the MCO Quality Strategy when aligned. Additionally, Table 8-1 is not intended to include all goals under the MCO and PAHP quality strategies. Rather, Table 8-1 includes only the goals (overarching goals or individual goals) substantially influenced by the data and results produced by the EQR activities and current MCP contract requirements.

Table 8-1—Programwide Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Behavioral Health	**Conclusions:** The Iowa Managed Care Program demonstrated strong performance as indicated by the results of the HEDIS activity for the *Follow-Up After ED Visit for AOD Abuse or Dependence; Follow-Up After ED Visit for Mental Illness; Follow-Up After Hospitalization for Mental Illness;* and *Initiation and Engagement of AOD Abuse or Dependence Treatment* performance measures. All rates except those for *Follow-Up After Hospitalization for Mental Illness*, which ranked at or above the 75th percentile but below the 90th percentile, ranked at or above the 90th percentile. Also, the rates for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* performance measures ranked at or above the 50th percentile but below the 75th percentile. The NAV activity further confirmed that the MCOs overall had a sufficient network of outpatient and inpatient behavioral health providers to deliver services to Iowa's managed care members. However, the remaining two performance measures under the Behavioral Health domain of the HEDIS activity have continued opportunities for improvement. The rate for *Diabetes Monitoring for People With Diabetes and Schizophrenia* ranked at or above the	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	25th percentile but below the 50th percentile, and the rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics* ranked below the 25th percentile. **Recommendations:** Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS consider revising its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. Additionally, while HHS requires the MCOs to conduct two mandated PIPs, HHS could add a provision to the contract requiring the MCOs to engage in two additional PIPs per year (e.g., two HSAG-validated PIPs and two non-HSAG validated PIPs). HHS could specify the topics or areas the PIPs must address. One of these topics could be related to behavioral health. Further, HHS could consider setting MPSs or performance thresholds for a select number of HEDIS performance measures which align with HHS' Quality Strategy goals. While these performance thresholds may or may not be tied to a payment incentive, setting a statewide performance threshold will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress in meeting HHS' established Quality Strategy goals and objectives.	
Access to Care	**Conclusions:** The results of the HEDIS activity demonstrated mixed results programwide related to primary and specialty care (excluding behavioral health and prenatal and postpartum care which are addressed under a different HHS Quality Strategy goal): • *Access to Preventive Care* domain—One performance measure rate ranked at or above the 75th percentile but below the 90th percentile, two rates ranked at or above the 50th percentile but below the 75th percentile, three rates ranked at or above the 25th percentile but below the 50th percentile, and one rate ranked below the 25th percentile. • *Women's Health* domain—Two performance measure rates ranked at or above the 50th percentile but below the 75th percentile, two rates ranked at or above the 25th percentile but below the 50th percentile, and two rates ranked below the 25th percentile.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	• *Living With Illness* domain—One performance measure rate ranked at or above the 90th percentile, two rates ranked at or above the 75th percentile but below the 90th percentile, three rates ranked at or above the 50th percentile but below the 75th percentile, and two rates ranked below the 25th percentile. • *Keeping Kids Healthy* domain—One performance measure rate ranked at or above the 75th percentile but below the 90th percentile, five rates ranked at or above the 50th percentile but below the 75th percentile, one rate ranked at or above the 25th percentile but below the 50th percentile, and one rate ranked below the 25th percentile. • *Medication Management* domain—Two performance measure rates ranked at or above the 75th percentile but below the 90th percentile, seven rates ranked at or above the 50th percentile but below the 75th percentile, eight rates ranked at or above the 25th percentile but below the 50th percentile, and one rate ranked below the 25th percentile. Programwide, the highest-ranking performance measure was *Comprehensive Diabetes Care—HbA1c Testing,* while the lowest-ranking performance measures included *Use of Imaging Studies for Low Back Pain*, *Chlamydia Screening in Women*, *Statin Therapy for Patients With Cardiovascular Disease*, *Statin Therapy for Patients With Diabetes*, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*, and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*. Additionally, while no national comparisons or MPSs are available, the dental services performance measure rates were generally low: *Members Who Accessed Dental Care*—17.29 percent to 29.09 percent; *Members Who Received Preventive Dental Care*—35.86 percent to 71.93 percent; and *Members Who Received a Preventive Examination and a Follow-Up Examination Percentage*—39.62 percent to 59.69 percent. Further, through the NAV activity, the MCPs generally had sufficient provider networks, suggesting that members were experiencing other barriers to accessing primary, specialty, and dental care and services. **Recommendations:** Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS consider revising its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. While HHS requires the MCOs to conduct two mandated PIPs, HHS could also add a provision to the contract requiring the MCOs to engage in two additional PIPs per year (e.g., two HSAG-validated PIPs and two non-HSAG validated PIPs). HHS could specify the topics or areas the PIPs must address. Options for these topics could include prevention and care of acute and chronic conditions, high-risk services, oral health, etc. Additionally, through the NAV activity for the MCPs, provider-to member ratios where calculated. However, HHS does not have established MPSs. As such, HHS could update its network adequacy standards to include minimum required provider-to-member ratios for PCPs, specialists, and dentists. Further, as a new MCO is scheduled to join the Iowa Managed Care Program effective July 1, 2023, and membership will be reassigned across three MCOs, HHS could consider a disruption analysis in future NAV activities. A disruption analysis may provide HHS with valuable information on whether members retained access to their PCPs, and whether provider networks and time/distance access standards were impacted. Lastly, HHS could consider setting MPSs or performance thresholds for a select number of HEDIS performance measures which align with HHS' Quality Strategy goals. While these performance thresholds may or may not be tied to a payment incentive, setting a statewide performance threshold will assist HHS in quantitatively evaluating the Iowa Medicaid Managed Care Program's progress in meeting HHS' established Quality Strategy goals and objectives.	
Improving Coordinated Care	**Conclusions:** HHS required the MCOs to conduct a PIP related to *Timeliness of Postpartum Care*. Both MCOs received an overall validation status of *Met*, indicating the MCOs conducted appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement. Additionally, both MCOs demonstrated successes. Amerigroup's performance indicator achieved a rate of 76.9 percent, demonstrating a statistically significant improvement from the baseline rate which was 68.9 percent. Iowa Total Care also demonstrated programmatically significant improvement over the baseline performance through the implementation of provider education and member outreach which increased the number of pregnancy notifications received by the MCO from 2020 to 2021. Further, the programwide rate for the *Postpartum Care* indicator under the *Prenatal and Postpartum Care* performance measure ranked at or above the 50th percentile but below the 75th percentile, indicating many women had a postpartum	☒ Quality ☒ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	visit on or between seven and 84 days after delivery of their baby. However, while not identified as an individual goal under HHS' MCO Quality Strategy goal, *Improving Coordinated Care*, the related *Timeliness of Prenatal Care* rate under the *Prenatal and Postpartum Care* performance measure ranked below the 25th percentile, indicating that many pregnant women receiving services under the Iowa Managed Care Program did not receive a timely prenatal care visit within the first trimester. Prenatal care is critical in ensuring healthy outcomes for new mothers and their babies, including a healthy birth weight. **Recommendations:** Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS consider revising its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. While the Iowa Managed Care Program is performing poorly when compared to national percentiles regarding timely prenatal care, both MCOs demonstrated an improvement in performance from MY 2020 to MY 2021 (for Amerigroup, the rate increased 3.41 percentage points and for Iowa Total Care, the rate increased by 5.84 percentage points). Additionally, while there are continued opportunities to increase the number of pregnant women receiving timely prenatal care, the percentage of low birth weights for the Iowa Medicaid and CHIP population is 7.7 percent, which is below the national median rate of 9.7 percent (a lower rate indicates better performance).[8-1] As such, HHS should closely monitor year-over-year and long-term trending for the *Timeliness of Prenatal Care* rate and low birth weight for the Iowa Medicaid population for continued improvement. HHS should implement statewide improvement initiatives for any noted decrease in performance (i.e., decrease is the *Timeliness of Prenatal Care* rate, increase in low birth weight rates, and the correlation between the two measures). HHS could consider a statewide collaborative to identify the impact that untimely prenatal care has on member outcomes such as live	

[8-1] Centers for Medicare & Medicaid Services. Live Births Weighing Less Than 2,500 Grams. Available at: https://www.medicaid.gov/state-overviews/scorecard/live-births-weighing-less-than-2500-grams/index.html. Accessed on: Feb 1, 2023.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	births, low birth weight and pre-term births, and the financial impact to the Iowa Medicaid Managed Care Program due to poor outcomes.	
Continuity of Care	**Conclusions:** HHS' contract with the MCPs requires the MCPs to implement mechanisms to ensure the continuity of care for members transitioning in and out of the MCPs' enrollment. These mechanisms include, but are not limited to, ensuring members have access to services consistently through the transition process; referring members to appropriate in-network providers; ensuring that MCPs fully comply with requests for historical utilization data in a timely manner; and ensuring new providers are able to obtain copies of a member's medical or dental record. Possible transitions include initial program implementation, initial enrollment with an MCP, transitions between MCPs during the initial 90 days of a member's enrollment, and at any time for cause. Additionally, through the PMV activity, HHS focused on a set of state-specific performance measures related to members receiving HCBS and the provision of person-centered care planning. Through the person-centered care planning process, the MCOs should also be addressing transitions of care between care settings. One of the measures validated through the PMV activity is *Member Choice of Home and Community-Based Services (HCBS) Settings*. A member's care plan must document the member's choice and/or placement in alternative HCBS settings. Should a member be transitioning from one setting to another setting, the person-centered planning process should address continuity of care and access to services during the transition. **Recommendations:** Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS revise its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. Additionally, the HCBS performance measures validated through the PMV activity do not have set MPSs and are not specifically addressed in HHS' MCO Quality Strategy. HHS should consider revising/updating its current Quality Strategy goals to include a measurable objective related to the HCBS performance measures. Alternatively, if HHS is not	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	formally using the HCBS performance measures to measure and monitor MCO performance, HSAG recommends that HHS consider retiring these measures from the PMV activity and select new measures for validation that HHS can use to measure MCO performance. Further, as the membership of the Iowa Managed Care Program will be redistributed when a new MCO joins the program effective July 1, 2023, HHS should closely monitor and immediately address with the MCOs, any disruption in services reported by members, family members, providers, and other stakeholders.	
Health Equity	**Conclusions:** HHS requested that the results of the MCO NAV activity include a stratified analysis of health equity by race/ethnicity, urbanicity, age, and a concentrated disadvantage index. The results of the MCO NAV activity demonstrated that 100 percent of members have access to an adult PCP; 100 percent of members have access to a pediatric PCP; 100 percent of members have access to a behavioral health inpatient provider; and almost 100 percent of members have access to a behavioral health outpatient provider. These results confirm there were no or minimal variations by member urbanicity, race/ethnicity, age, or living in an area of concentrated disadvantage. Additionally, HHS has implemented a P4P program to reward the MCOs' efforts to improve quality and the health outcomes of members. The SFY 2022 program includes a performance measure related to the MCOs' health equity plans. To receive the incentive payment, the MCOs are required to submit a health equity plan that includes but is not limited to policies and procedures that demonstrate organizational attention to health equity focus areas; strategic goals; the measures and metrics used to track progress toward achieving the strategic goals; and the measurement and evaluation of each strategic goal. Further, as demonstrated through the compliance review activity and QAPI program, one MCO was a recipient of the NCQA Distinction in Multicultural Healthcare. Both MCOs also adhered to national CLAS standards to identify and reduce care deficiencies related to CLAS and health disparities. **Recommendations:** Currently, HHS has separate and distinct quality strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS revise its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. Additionally, while HHS' contract with the PAHPs require the PAHPs to deliver services to all members in a culturally competent manner, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity, it did not include any specific provisions addressing health equity in dental care. HHS could consider strengthening contract language to address health equity; for example, requiring the PAHPs to conduct an assessment of existing health disparities, including disparities identified through the results of performance measure reporting, and develop a formal health equity plan. HHS could also consider applying the MCO NAV activity methodology to the PAHP NAV activity and stratify PAHP results by race/ethnicity, urbanicity, age, and a concentrated disadvantage index.	
Voice of the Customer	**Conclusions:** HHS required the MCOs to conduct a PIP related to *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed.* Both MCOs received an overall validation status of *Met*, indicating the MCOs conducted appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement. While both MCOs demonstrated an increase in the *Customer Service at Child's Health Plan Gave Information or Help Needed* rate from the baseline rate to Remeasurement 1, the improvement was not statistically significant. However, Iowa Total Care did achieve programmatically significant improvement over the baseline performance through the implementation of after-call surveys and quality checks to ensure member services agents were performing as expected. The average score for the member services department increased by 2 percent from 2020 to 2021. HHS also requires the MCOs to report on their CAHPS data annually. Programwide rates indicate that no measure was statistically significantly lower than the 2021 national average. Further, rates for several measures were statistically significantly higher than the 2021 national average: *Getting Needed Care* and *Getting Care Quickly* for the adult population; and *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor* for the child population. Additionally, HHS requires the MCOs to conduct the IPES for members receiving home and community-based services (HCBS). It was confirmed through the compliance review activity and a review of Standard XIV—Quality Assessment and Performance Improvement Program, that both MCOs implemented the IPES survey and reported the results to HHS quarterly.	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	However, the programwide score for Standard X—Grievance and Appeal Systems of the compliance review activity was 89 percent. All MCPs demonstrated opportunities to improve implementation of grievance and appeal processes to ensure adherence to all federal and State contract requirements. Strict adherence to these requirements is needed to ensure the MCPs collect complete and accurate information to review reports and make recommendations for improvement, including increasing member satisfaction when concerns are identified. **Recommendations:** Currently, HHS has separate and distinct Quality Strategies for the MCOs and PAHPs. To support integration of all Iowa managed care programs, HSAG recommends that HHS revise its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective applies to the MCOs, PAHPs, or both. Additionally, while HHS' contract with the PAHPs suggests that HHS will use the results of any member satisfaction surveys conducted by the PAHPs, HHS could strengthen contract language by requiring the PAHPs to conduct a member satisfaction survey annually. Additionally, as HHS' Quality Strategy for the PAHPs does not specifically address member satisfaction, HHS could consider setting a PAHP performance objective under the *Voice of the Customer* overarching goal.	

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting External Quality Review Activities

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory external quality review activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), MCPs are required to have a quality assessment and performance improvement program which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and 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 MCPs' PIPs, HSAG used the CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[A-1]

HSAG's validation of PIPs includes two key components of the QI process:

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

[A-1] 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: Jan 23, 2023.

Technical Methods of Data Collection and Analysis

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

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

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

Step 1. Review the Selected PIP Topic
Step 2. Review the PIP Aim Statement
Step 3. Review the Identified PIP Population
Step 4. Review the Sampling Method
Step 5. Review the Selected Performance Indicator(s)
Step 6. Review the Data Collection Procedures
Step 7. Review the Data Analysis and Interpretation of PIP Results
Step 8. Assess the Improvement Strategies
Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate PIPs conducted by the MCPs 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 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 MCPs 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 Feedback with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP steps 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 MCPs had an opportunity to resubmit a revised PIP Submission Form and additional information in response to HSAG's initial validation scores of *Partially Met* or *Not Met* and to address any General Feedback, regardless of whether the evaluation element was critical or noncritical. HSAG conducted a final validation for any resubmitted PIPs. HSAG offered technical assistance to any MCP that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

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

Description of Data Obtained and Related Time Period

For CY 2022, the MCOs submitted Remeasurement 1 data for their two PIP topics. The MCOs used CAHPS measure specifications for the *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed* PIP topic and HEDIS measure specifications for the *Timeliness of Postpartum Care* PIP. The PAHPs submitted the PIP Design (Steps 1 through 6) and baseline data for their new PIP topics. The PAHPs used HHS-defined specifications in collecting their performance indicator data. The measures used for MCP PIPs were related to the domains of quality of care and access to care.

HSAG obtained the data needed to conduct the PIP validation from the MCOs' PIP Submission Form. These forms provide annual performance indicator data and detailed information about each PIPs aim statements, sampling and data collection methods and the QI activities completed. Table A-1 displays a description of the data obtained for each PIP topic.

Table A-1—MCO Data Obtained for Each PIP Topic

AGP PIP Topics	Aim Statements	Sampling Methods	Data Sources
Timeliness of Postpartum Care	Do targeted interventions increase the total percentage of completed postpartum visits by members on or between 7 and 84 days after a delivery?	The MCO utilized the NCQA guidelines for sampling.	• Medical record abstraction • Electronic health record abstraction • Administrative claims/encounters • Supplemental data

AGP PIP Topics	Aim Statements	Sampling Methods	Data Sources
CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	Do targeted interventions increase the percentage of members who answer CAHPS child survey Question #50 (AGP Q45) Customer Service at a Child's Health Plan gave information or help needed, with a response of usually or always?	The MCO utilized the NCQA guidelines for sampling.	• Survey data
ITC PIP Topics	**Aim Statements**	**Sampling Methods**	**Data Sources**
Timeliness of Postpartum Care	Do targeted interventions for women that have a postpartum visit on or between 7–84 days after delivery result in an increase of 2% from baseline rate?	The MCO utilized the NCQA guidelines for sampling.	• Medical record abstraction • Electronic health record abstraction • Administrative claims/encounters • Supplemental data
CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	To increase the percentage of "Always" or "Usually" responses from the Child CAHPS survey question "Customer Services at Child's Health Plan gave help or information needed" from the baseline rate by 2%.	The MCO utilized the NCQA guidelines for sampling.	• Survey data

HSAG obtained the data needed to conduct the PIP validation from the PAHPs annual PIP Submission Form. These forms provide annual performance indicator data and detailed information about each PIPs aim statements, sampling and data collection methods and the QI activities completed. Table A-2 displays a description of the data obtained for each PIP topic.

Table A-2—PAHP Data Obtained for Each PIP Topic

DDIA PIP Topic	Aim Statements	Sampling Methods	Data Sources
Annual Preventative Dental Visits	1. Do targeted interventions increase the percentage of Dental Wellness Plan (DWP Adults) members 19 years and older who had at least one preventive dental visit during the measurement year?	Sampling was not used.	• Administrative claims/encounters

DDIA PIP Topic	Aim Statements	Sampling Methods	Data Sources
	2. Do targeted interventions increase the percentage of Hawki (Hawki) members 18 years of age and younger who had at least one preventive dental visit during the measurement year? 3. Do targeted interventions increase the percentage of Dental Wellness Plan Kids (DWP Kids) members 18 years of age and younger who had at least one preventive dental visit during the measurement year		
MCNA PIP Topic	**Aim Statements**	**Sampling Methods**	**Data Sources**
Increase the Percentage of Dental Services	1. Do targeted interventions increase the percentage of Dental Wellness Plan (DWP Adults) members 19 years and older who had at least one preventive dental visit during the measurement year? 2. Do targeted interventions increase the percentage of Dental Wellness Plan Kids (DWP Kids) members 18 years of age and younger who had at least one preventive dental visit during the measurement year?	Sampling was not used.	• Administrative claims/encounters

The MCPs submitted each PIP Submission Form according to the approved timeline. After initial validation, the MCPs received HSAG's feedback, an opportunity for technical assistance and resubmitted the PIP Submission Form for final validation. Table A-3 and Table A-4 display the indicator measurement periods for all PIP topics for the MCPs.

Table A-3—MCO Measurement Periods for PIP Topics

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

Table A-4—PAHP Measurement Periods for Both PIP Topics

Data Obtained	Measurement Period
Baseline	July 1, 2021—June 30, 2022
Remeasurement 1	July 1, 2022—June 30, 2023
Remeasurement 2	July 1, 2023—June 30, 2024

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that the MCPs provided to members, HSAG validated the PIPs to ensure that the MCPs used a sound methodology in their design, implementation, analysis, and reporting of the PIP's findings and outcomes. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *Met*, *Partially Met*, or *Not Met*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to baseline, prior remeasurement period results, and project goal) and qualitative results (e.g., technical design of the PIP, data analysis, and implementation of improvement strategies) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCPs' Medicaid members.

Performance Measure Validation

Activity Objectives

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

[A-2] 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: Jan 23, 2023.

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

Technical Methods of Data Collection and Analysis

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

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The MCPs were required to submit a completed ISCAT that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation of the required HHS-developed measures. HSAG reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance measures**—The MCPs that calculated the performance measures using computer programming language were required to submit source code for each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications defined by HHS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). MCPs that did not use computer programming language to calculate the performance measures were required to submit documentation describing the actions taken to calculate each measure.
- **Supporting documentation**—The MCPs 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 HHS for validation.

In collaboration with HHS, HSAG prepared a documentation request letter that was submitted to the MCPs, which outlined the steps in the PMV process. The documentation request letter included a request for the source code for each performance measure, a completed ISCAT, and any additional supporting documentation necessary to complete the audit. The letter also included a timeline for completion and instructions for the MCPs to submit the required information to HSAG. HSAG responded to any audit-related questions received directly from the MCPs.

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

PMV Review Activities

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

- **Opening and organizational review**—This interview session included introductions of HSAG's validation team and key MCP staff involved in the support of the MCPs' information systems and its calculation and reporting of the performance measures. HSAG reviewed expectations for the virtual review, discussed the purpose of the PMV activity, and reviewed the agenda and general audit logistics. This session also allowed the MCPs to provide an overview of its organizational operations and any important factors regarding its information systems or performance measure activities.
- **Review of key information systems and data processes**—Drawing heavily on HSAG's desk review of the MCPs' ISCAT responses, these interview sessions involved key MCP staff responsible for maintaining the information systems and executing the processes necessary to produce the performance measure rates. HSAG conducted interviews to confirm findings based on its documentation review, expanded, or clarified outstanding questions, and ascertained that written policies and procedures were used and followed in daily practice. Specifically, HSAG staff evaluated the systems and processes used in the calculation of selected performance measures.
  - **Enrollment, eligibility, provider, and claims/encounter systems and processes**—These evaluation activities included a review of key information systems and focused on the data systems and processes critical to the calculation of measures. HSAG conducted interviews with key staff familiar with the collection, processing, and monitoring of the MCP data used in producing performance measures.
  - **Overview of data integration and control procedures**—This session included a review of the database management systems' processes used to integrate key source data and the MCPs' calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
  - **System demonstrations**—HSAG staff requested that MCP staff demonstrate key information systems, database management systems, and analytic systems to support documented evidence and interview responses.
- **PSV**—HSAG performed additional validation using Primary Source Validation to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across evaluated measures to verify that the MCPs had appropriately applied measure specifications for accurate rate reporting. The MCPs provided HSAG with a listing of the data the MCPs had reported to HHS from which HSAG randomly selected a sample of cases and requested that the MCPs provide proof of service documentation. During the virtual review, these data were reviewed live in the MCPs' systems for verification. This approach enabled the MCPs 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 MCP. The completed ISCATs provided HSAG with background information on the MCPs' policies, processes, and data in preparation for the virtual review validation activities.
- **Source Code (Programming Language) for Performance Measures—**HSAG obtained source code from each MCP (if applicable). If the MCPs did not produce source code to generate the performance indicators, the MCPs 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 MCPs.
- **Current Performance Measure Results—**HSAG obtained the calculated results from the MCPs.
- **Supporting Documentation—**This documentation provided additional information needed by HSAG reviewers to complete the validation process. Documentation included performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Virtual Interviews and Demonstrations—**HSAG also obtained information through discussion and formal interviews with key MCP staff members as well as through systems demonstrations.

Table A-5 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table A-5—Description of MCP Data Sources

Data Obtained	Time Period to Which the Data Applied	
	AGP	ITC
Completed ISCAT	SFY 2022	
Source code for each performance measure		
Performance measure results		
Supporting documentation		
Virtual on-site interviews and systems demonstrations	July 12, 2022	July 11, 2022

Additionally, HHS provided HSAG with each MCP's audited HEDIS rates for HHS-selected measures, and HSAG reviewed the rates in comparison to national Medicaid percentiles to identify strengths and opportunities for improvement.

Table A-6 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table A-6—Description of PAHP Data Sources

Data Obtained	Time Period to Which the Data Applied	
	DDIA	MCNA
Completed ISCAT	SFY 2022	
Source code for each performance measure		
Performance measure results		
Supporting documentation		
Virtual on-site interviews and systems demonstrations	July 20, 2022	July 18, 2022

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that the MCPs provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, *Not Applicable*, or *Not Reported*. HSAG further analyzed the quantitative results (e.g., performance indicator results) and qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with HHS, performed compliance reviews of the MCPs contracted with HHS to deliver services to Iowa Medicaid managed care members.

HHS requires its MCPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The CY 2022 compliance review is the second year of the three-year cycle of compliance reviews that commenced in CY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews in Iowa consist of 14 program areas referred to as standards. HHS requested that HSAG conduct a review of the first seven standards in Year One (CY 2021). and a review of the

remaining seven standards in Year Two (CY 2022). In Year Three (CY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the CY 2021 and CY 2022 compliance reviews. The division of standards over the three years can be found in Table A-7.

Table A-7—Three-Year Cycle of Compliance Reviews

Standards	Associated Federal Standards[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of MCP implementation of Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

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

[2] The Health Information Systems standard includes an assessment of each MCP's IS capabilities.

Technical Methods of Data Collection and Analysis

Prior to beginning the 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 HHS and the MCP as they related to

the scope of the review. HSAG also followed the guidelines set forth in CMS EQR Protocol 3 for the following activities:

Pre-review activities included:

- Collaborated with HHS to develop scope of work, compliance review methodology, and compliance review tools.
- Prepared and forwarded to the MCP a timeline, description of the compliance process, pre-audit information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the compliance review with the MCPs.
- Hosted a pre-audit preparation session with all MCPs.
- Generated a list of 10 sample records for practitioner credentialing, organizational credentialing, grievances, appeals, and three sample records for delegate case file reviews.
- Conducted a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from HHS, and of documents the MCP submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the MCP's operations, identify areas needing clarification, and begin compiling information before the site review.
- Followed up with the MCP, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the one-day compliance review interview sessions and provided the agenda to the MCP to facilitate preparation for HSAG's review.

Compliance review activities included:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCP key program staff members.
- Conducted a review of practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities' records.
- Conducted an IS review of the data systems that the MCP used in its operations applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-review activities:

- Conducted a review of additional documentation submitted by the MCP.
- Documented findings and assigned each element a score (*Met*, *Not Met*, or *NA* as described in the following Data Aggregation and Analysis section) within the compliance review tool.
- Prepared an MCP-specific report and CAP template for the MCP to develop and submit its remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCP during the period covered by HSAG's review. This scoring methodology is consistent with CMS' Protocol 3.

- ***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.
  - Documentation, staff responses, case file reviews, and IS reviews confirm implementation of the requirement.

- ***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.
  - Documentation, staff responses, case file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
  - No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
  - For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each 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 MCP were scored *NA* and were not included in the denominator of the total score.

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

HSAG conducted file reviews of the MCP's records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities to verify that the MCP had put into practice what the MCP had documented in its policy. HSAG selected 10 records each for practitioner and organizational credentialing, grievances, appeals, and three delegated entities from the full universe of records provided by the MCP. The file reviews were not intended to be a statistically significant

representation of all the MCP's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCP staff members. Based on the results of the file reviews, the MCP must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

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

- Documented findings describing the MCP's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCP's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.
- 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 HHS for its review and comment prior to issuing final reports.

Remediation of Deficiencies

The MCPs were required to submit a CAP for all elements that received a *Not Met* score. For each element that required correction, the MCP identified the planned interventions to achieve compliance with the requirement(s), the individual(s) responsible, and the timeline. HSAG prepared a customized template for each MCP to facilitate the MCP's submission and HHS' and HSAG's review of corrective actions to determine the sufficiency of the CAP. The MCPs were required to resubmit CAPs until determined acceptable by HHS and HSAG.

Description of Data Obtained and Related Time Period

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.

- Narrative and/or data reports across a broad range of performance and content areas.
- Records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the MCP's key staff members. Table A-8 lists the major data sources HSAG used in determining the MCP's performance in complying with requirements and the time period to which the data applied.

Table A-8—Description of MCP 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 or after the site review	July 1, 2021–February 28, 2022
Information obtained through interviews	May 16–20, 2022
Information obtained from a review of a sample of practitioner and organizational credentialing files	Listing of all closed member grievances between July 1, 2021–February 28, 2022
Information obtained from a review of a sample of member appeal files	Listing of all closed appeals between July 1, 2021–February 28, 2022
Information obtained from a review of a sample of delegated entity files	Listing of all delegates serving the Iowa Medicaid Managed Care Program between July 1, 2021–February 28, 2022

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each MCP individually, HSAG used the quantitative results and percentage-of-compliance score calculated for each standard. As any standard or program area not achieving 100 percent compliance required a formal CAP, HSAG determined each MCP's substantial strengths and weaknesses as follows:

- Strength—Any program area that achieved 100 percent compliance.
- Weakness—Any program area that received 80 percent or less compliance.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality and timeliness of, and access to care and services that the MCP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members.

Network Adequacy Validation

Activity Objectives

The goal of the network adequacy projects was to ensure the MCPs' members have adequate access to healthcare services. For the MCOs, HSAG assessed the members' access to PCPs and behavioral health providers. For the PAHPs, HSAG assessed whether the DWP, DWP Kids, and Hawki members have adequate access to dental provider services available through one of the dental PAHPs.

Technical Methods of Data Collection and Analysis

MCOs

HSAG cleaned, processed, and defined the unique set of providers, provider locations, and members for inclusion in the analysis. All Medicaid member and provider files were standardized and geocoded using Quest Analytics software. The final Medicaid population used for analysis was limited to the MCO members residing within the State of Iowa. The full provider network identified by the MCOs was limited to provider locations in Iowa or locations in a county contiguous to Iowa. Table A-9 shows the provider specialties that were used to report the adequacy of the MCOs' PCP and behavioral health provider networks and the time/distance standards.

Table A-9—Provider Specialties Included in the Analysis

Provider Category	Provider Specialties Included	Time/Distance Standards
Primary Care Providers	• Family Practice • General Practice • Internal Medicine • Physician Assistant • Nurse Practitioner (NP) • Pediatric Medicine	30 miles or 30 minutes
Behavioral Health Providers	• Addiction (Substance Use Disorder) Providers • Behavioral Analysts • Counselor • Licensed Marriage and Family Therapy • Psychiatry (MD and NP) • Psychology • Social Work	*Outpatient:* 30 miles or 30 minutes *Inpatient, residential, intensive outpatient, and partial hospitalization:* 60 minutes or 60 miles urban areas; 90 minutes or 90 miles rural areas

Once the data files were received and processed for inclusion in the analysis, HSAG conducted the following analyses:

- *Provider Capacity Analysis*: HSAG compared the number of PCP and behavioral health providers associated with each MCO's provider network relative to the number of enrolled members.
- *Percentage of members with access to PCPs*: HSAG calculated the percentage of members who had access to PCPs within the time/distance standard, including stratified analyses of health equities by race/ethnicity, urbanicity, age, and a concentrated disadvantage index.
- *Percentage of members with access to behavioral health providers*: HSAG calculated the percentage of members who had access to behavioral health providers within the time/distance standard, including stratified analyses of health equities by race/ethnicity, urbanicity, age, and a concentrated disadvantage index.

PAHPs

HSAG cleaned, processed, and identified 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 geocoded. The final Medicaid populations included DWP, DWP Kids, and Hawki members residing within the State of Iowa. Once the data files were received and processed for inclusion in the analysis, HSAG conducted the following analyses:

- *Provider Capacity Analysis*: HSAG compared the number of dental providers associated with a PAHP's provider network relative to the number of enrolled members. This provider-to-member ratio represents a summary statistic used to highlight the overall capacity of a PAHP's dental provider network to deliver dental services to Medicaid members.
- *Calculation of the percentage of members in the new PAHP networks with access to general dentists within the access standards:* HSAG conducted a time/distance analysis assessing the percentage of DWP Kids members with access to a general dentist within the time/distance standards under the PAHP networks as shown in Table A-10.

Table A-10—Dental PAHP and Member Populations Served

Line of Business (LOB)	DDIA	MCNA
DWP (Adults)	✓	✓
DWP Kids	✓	✓
Hawki	✓	—

Description of Data Obtained and Related Time Period

MCOs

To complete the network analysis, HSAG obtained Medicaid member demographic information, Medicaid member enrollment information, and the MCOs' provider network data. The list below is a high-level summary of the data used:

- The member demographic data including key data elements such as the unique member identifier, sex, age, race/ethnicity, and residential address as of July 31, 2022.
- The member eligibility and enrollment files including the start and end dates for MCO enrollment as of July 31, 2022.
- The provider data contained providers actively enrolled in an MCO as of July 31, 2022. Some of the key data elements are unique provider identifier, enrollment status with the MCOs, provider type, provider specialty, and service address as of July 31, 2022.
- HSAG used the United States Census Bureau to obtain county-level information and findings from the five-year American Community Survey (ACS)[A-3] estimates from 2016–2020 for the calculation of the concentrated disadvantage index.

PAHPs

To complete the provider network analysis, HSAG obtained Medicaid member demographic information and the monthly network provider listing from HHS. Additionally, the PAHPs submitted a provider data file to HSAG. The list below is a high-level summary of the data used:

- HHS submitted member demographic data containing key data elements such as unique member identifier, gender, age, LOB, and residential address as of May 31, 2022.
- HHS submitted the monthly network provider listing which summarizes the provider networks as of May 31, 2022. Some of the key data elements are unique provider identifier, enrollment status with the PAHPs, provider type, provider specialty, and service address as of May 31, 2022. A separate provider network file was submitted for each PAHP and LOB.
- The PAHPs submitted the dental provider data which contains providers actively enrolled in a PAHP as of May 31, 2022. Some of the key data elements are unique provider identifier, enrollment status with the PAHPs, LOB served, provider category, and service address as of May 31, 2022.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each MCO provided to members, HSAG evaluated members' access to primary care and behavioral health

[A-3] United States Census Bureau, American Community Survey. Available at: https://www.census.gov/programs-surveys/acs/. Accessed on: Feb 23, 2023.

providers. HSAG further analyzed whether DWP, DWP Kids, and Hawki members had adequate access to dental provider services. HSAG used the NAV activity results to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of, timeliness of, and access to care and services furnished by the MCP's Medicaid managed care members.

Encounter Data Validation

Activity Objectives

HSAG's approach to conducting EDV studies is tailored to address the specific needs of its clients by customizing elements outlined in the CMS External Quality Review (EQR) Protocol. In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity,* October 2019,[A-4] in general, the following core evaluation steps describe HSAG's approach to conducting the EDV activity:

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

MCOs

During CY 2022, HSAG conducted the following two core evaluation activities for the EDV study: comparative analysis and MRR.

[A-4] 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 16, 2023.

The goal of the comparative analysis was to evaluate the extent to which encounters submitted to HHS by the MCOs are complete and accurate, based on corresponding information stored in the MCOs' data systems.

Medical and clinical records are considered the "gold standard" for documenting Medicaid members' access to quality healthcare services. As such, the goal of the MRR is to assess HHS' data quality through investigating the completeness and accuracy of HHS' encounters compared to the information documented in the corresponding medical records for Medicaid members.

PAHPs

For both PAHPs, HSAG conducted all of the core EDV activities previously; however, it has been nearly three years since the comparative analysis was conducted. As such, during CY 2022, HSAG conducted the comparative analysis component of the EDV study. The goal of the comparative analysis is to ensure and determine that each PAHP continues to submit complete and accurate dental encounter data.

Technical Methods of Data Collection and Analysis

MCOs

Comparative Analysis

Both Amerigroup and Iowa Total Care were included in this component of the EDV activity for CY 2022. In this activity, HSAG developed a data requirements document requesting claims/encounter data from both HHS and the MCOs. A follow-up technical assistance session occurred approximately one week after distributing the data requirements documents, thereby allowing the MCOs time to review and prepare their questions for the session. Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure data were sufficient to conduct the evaluation. The preliminary file review included the following basic checks:

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

Once HSAG received and processed the final set of data from HHS 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 HHS' data warehouse (record omission).
- The number and percentage of records present in HHS' 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-11. The analyses focused on an element-level comparison for each element.

Table A-11—Key Data Elements for Comparative Analysis

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

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 HHS' data warehouse (element omission).
- The number and percentage of records with values present in HHS' 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 HHS' 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 HHS' 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 HHS 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 HHS' 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 HHS 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 HHS to determine whether the issues were addressed.

Medical Record Review

Both Amerigroup and Iowa Total Care were included in the MRR component of the CY 2022 EDV study. As outlined in the CMS protocol, MRR is a complex, resource-intensive process. Medical and clinical records are considered the "gold standard" for documenting access and the quality of healthcare services.

The MRR activity evaluated encounter data completeness and accuracy through a review of medical records for physician services rendered between July 1, 2020, and June 30, 2021. This component of the study answered the following question:

Are the data elements in Table A-12 found on the professional encounters complete and accurate when compared to information contained within the medical records?

Table A-12—Key Data Elements for MRR

Key Data Element	
Date of Service	Diagnosis Code
Procedure Code	Procedure Code Modifier

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

- Identified the eligible population and generated samples from data extracted from the HHS data warehouse.
- Assisted Amerigroup to procure medical records from providers, as appropriate.
- Reviewed medical records against HHS' encounter data.
- Calculated study indicators based on the reviewed/abstracted data.
- Drafted report based on study results.

Study Population

To be eligible for the MRR, a member had to be continuously enrolled in the same MCO during the study period (i.e., between July 1, 2020, and June 30, 2021), and had to have had at least one professional visit during the study period. In addition, members with Medicare or other insurance coverages were excluded from the eligible population since HHS may not have all services they received that were covered by either Medicare and/or other insurances (but were documented in the members' medical records). After reviewing the encounter data extracted from the HHS data warehouse, HSAG discussed with HHS how to identify "professional visits" from the encounter data, as needed.

Sampling Strategy

HSAG used a two-stage sampling technique to select samples based on the member enrollment and encounter data extracted from the HHS data warehouse. HSAG first identified all members who met the study population eligibility criteria, and then used random sampling to select 411 members[A-5] from the eligible population for Amerigroup. Then, for each selected sampled member, HSAG used the SURVEYSELECT procedure in SAS®,[A-6] to randomly select one professional visit [A-7] that occurred in the study period (i.e., between July 1, 2020, and June 30, 2021). Additionally, to evaluate whether any dates of service were omitted from the HHS data warehouse, HSAG reviewed a second date of service rendered by the same provider during the review period. The providers selected the second date of service, which was closest to the sampled date of service, from the medical records for each sampled member. If a sampled member had no second visit with the same provider during the review period, HSAG evaluated only one date of service for that member. As such, for Amerigroup, the final number of visits reviewed was between 411 and 822.

Medical Record Procurement

Upon receiving the final sample list from HSAG, Amerigroup was responsible for procuring the sampled members' medical records from its contracted providers for services that occurred during the study period. In addition, Amerigroup was responsible for submitting the documentation to HSAG. To

[A-5] The sample size of 411 is based on a 95 percent confidence level and a margin of error of 5 percent.

[A-6] 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-7] To ensure that the MRR includes 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.

improve the procurement rate, HSAG conducted a one-hour technical assistance session with Amerigroup to review the EDV project and the procurement protocols after distributing the sample list. Amerigroup was instructed to submit medical records electronically via a Secure Access File Exchange (SAFE) site to ensure the protection of personal health information. During the procurement process, HSAG worked with Amerigroup to answer questions and monitor the number of medical records submitted. For example, HSAG provided an initial submission 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 medical records HSAG receives 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 MRR and research activities, HSAG had implemented a thorough Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and protection program in accordance with federal regulations that included recurring training as well as policies and procedures that addressed physical security, electronic security, and day-to-day operations.

Review of Medical Records

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

During the MRR 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 elements identified in sample cases and compared to corresponding documentation in the medical record. Interrater reliability among reviewers, as well as reviewer accuracy, were evaluated regularly throughout the study. Issues and decisions raised during the 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 on an ongoing basis to ensure the abstraction results were complete, accurate, and consistent.

The validation of encounter data incorporated a unique two-way approach through which encounters were chosen from both the electronic encounter data and from medical records and were subsequently compared with one another. Claims/encounters selected from encounter data received from HHS were compared against the medical record; and visit information from the medical record were compared against encounter data received from HHS. This process allowed the study to identify services

documented in the members' medical records and that are missing from the HHS system (i.e., *encounter data omission*), as well as identify encounters present in the HHS data warehouse but not documented in the members' medical records (i.e., *medical record omission*). For services in both data sources, an analysis of coding accuracy was completed. Information that existed in both data sources but whose values did not match were considered discrepant.

Study Indicators

Once the MRR was completed, HSAG analysts exported information collected from the electronic tool, reviewed the data, and conducted the analysis. HSAG used four study indicators to report the MRR results:

- *Medical record omission rate*: the percentage of dates of service identified in the electronic encounter data that were not found in the members' medical records. HSAG also calculated this rate for the other key data elements in Table A-12.
- *Encounter data omission rate*: the percentage of dates of service from members' medical records that were not found in the electronic encounter data. HSAG also calculated this rate for the other key data elements in Table A-12.
- *Accuracy rate of coding*: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that were correctly coded based on the members' medical records.
- *Overall accuracy rate:* the percentage of dates of service with all data elements coded correctly among all the validated dates of service from the electronic encounter data.

PAHPs

Comparative Analysis

Both Delta Dental and MCNA Dental were included in this component of the EDV activity for CY 2022. In this activity, HSAG developed a data requirements document requesting claims/encounter data from both HHS and the PAHPs. A follow-up technical assistance session occurred approximately one week after distributing the data requirements documents, thereby allowing the PAHPs time to review and prepare their questions for the session. Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure data were sufficient to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Data were extracted based on the data requirements document.
- Percentage present—Required data fields were present on the file and have values in those fields.
- Percentage of valid values—The values included were the expected values (e.g., valid CDT codes in the procedure code field).
- Evaluation of matching claim numbers—The percentage of claim numbers that matched between the data extracted from HHS' data warehouse and the PAHPs' data submitted to HSAG.

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

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

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

- The number and percentage of records present in the PAHPs' submitted files but not in HHS' data warehouse (record omission).
- The number and percentage of records present in HHS' data warehouse but not in the PAHPs' 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-13. The analyses focused on an element-level comparison for each data element.

Table A-13—Key Data Elements for Comparative Analysis

Key Data Elements	Dental
Member Identification (ID)	✓
Header Service From Date	✓
Header Service To Date	✓
Billing Provider NPI	✓
Rendering Provider NPI	✓
CDT Code	✓
Units of Service	✓
Tooth Number	✓
Tooth Surface (1 through 5)	✓
Oral Cavity Code (1 through 5)	✓
Detail Paid Amount	✓
Header Paid Amount	✓

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

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

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

- The number and percentage of records with the same values in both the PAHPs' submitted files and HHS' 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).

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

Description of Data Obtained and Related Time Period

MCOs

Medical Record Review

HSAG used data obtained from HHS which included member enrollment and demographic data, provider data, and professional encounter data for the MCOs. The study included physician services rendered between July 1, 2020, and June 30, 2021. Additionally, to be eligible for the MRR, a member had to be continuously enrolled in the same MCO during the study period (i.e., between July 1, 2020, and June 30, 2021) and had to have at least one physician visit during the study period. HSAG also used the sampled members' medical records, procured by the MCOs from its contracted providers for services that occurred during the study period.

Comparative Analysis

HSAG used professional, institutional, and pharmacy encounter data from HHS and the MCOs with dates of service from July 1, 2020, through June 30, 2021, to evaluate the accuracy and completeness of the encounter data. Both paid and denied encounters were included in the analysis. To ensure that the data extracted from both sources represented the same universe of encounters, the data targeted dental encounters submitted to HHS on or before February 28, 2022. This anchor date allowed sufficient time for the encounters to be submitted, processed, and available for evaluation in HHS' data warehouse.

PAHPs

Comparative Analysis

HSAG used dental encounter data from HHS and the PAHPs with dates of service from July 1, 2020, through June 30, 2021, to evaluate the accuracy and completeness of the dental encounter data. Both paid and denied encounters were included in the analysis. To ensure that the data extracted from both sources represented the same universe of encounters, the data targeted dental encounters submitted to HHS on or before December 31, 2021. This anchor date allowed sufficient time for the encounters to be submitted, processed, and available for evaluation in HHS' data warehouse.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of each MCP's encounter data submissions to HHS, HSAG evaluated the results based on the EDV core activities. HSAG calculated the predefined study indicators and/or metrics associated with each of the study components. Since HHS had not yet established standards for results from these activities, to identify strengths and weaknesses, HSAG assessed the results based on the prior year results, when available. HSAG also used its experience in working with other states in assessing the completeness, accuracy, and timeliness of MCPs' encounter data submissions to the State. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality and timeliness of encounter data submitted to HHS.

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 the MCOs: adult Medicaid and child Medicaid. Center for the Study of Services (CSS) and SPH Analytics, NCQA-certified vendors, administered the 2022 CAHPS surveys for Amerigroup and Iowa Total Care, respectively.

The technical methods of data collection were through the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult population, the CAHPS 5.1H Child Medicaid Health Plan Survey (with the CCC measurement set) to Amerigroup's child Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (without the CCC measurement set) to Iowa Total Care's child Medicaid population. Amerigroup and Iowa Total Care used a mixed-mode methodology for data collection. Amerigroup respondents were given the option of completing the survey in Spanish. Iowa Total Care respondents were given the option of completing the survey in Spanish, as well as completing the survey on the Internet.

CAHPS Measures

The survey questions were categorized into various measures of member experience. These measures included four global ratings, four composite scores, and three Effectiveness of Care measures for the adult population only. Additionally, five CCC composite measures/items were used for the CCC-eligible population.[A-8] 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

HSAG compared each MCO's and the MCO program's (i.e., Amerigroup and Iowa Total Care combined) results to the 2021 NCQA national averages to determine if the results were statistically significantly different. Colored arrows in the tables note statistically significant differences. A green upward arrow (↑) indicates a top-box score was statistically significantly higher than the 2021 NCQA national average. Conversely, a red downward arrow (↓) indicates a top-box score was statistically significantly lower than the 2021 NCQA national average. In some instances, the scores presented for the MCOs were similar, but one was statistically significantly different from the national average and the other was not. In these instances, it was the difference in the number of respondents between the two MCOs that explained the different statistical results. It is more likely that a statistically significant result

[A-8] ITC administered the CAHPS 5.1H Child Medicaid Health Plan Survey without the CCC measurement set; therefore, results for the CCC Medicaid population are not available and cannot be presented.

will be found in an MCO with a larger number of respondents. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as NA.

Description of Data Obtained and Related Time Period

Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2021, and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2021. Adult members and parents or caretakers of child members completed the surveys from February to May 2022.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each MCO provided to members, HSAG assigned each of the measures to one or more of these three domains and compared each MCO's and the MCO program's (i.e., Amerigroup and Iowa Total Care combined) 2022 survey results to the 2021 NCQA national averages to determine if there were any statistically significant differences. This assignment to domains is depicted in Table A-14.

Table A-14—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Advising Smokers and Tobacco Users to Quit	✓		
Discussing Cessation Medications	✓		
Discussing Cessation Strategies	✓		

Scorecard

Activity Objectives

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

already have a QRS in place will have an opportunity to use their current QRS to meet CMS requirements. CMS will require states wanting to use an alternative QRS to submit their methodology, including the list of performance measures included in the QRS to CMS.

The scorecard is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection and Analysis

MCO performance was evaluated in six separate reporting categories, identified as important to consumers.[A-9] Each reporting category consists of a set of measures that were evaluated together to form a category summary score. The reporting categories and descriptions of the types of measures they contain are listed below:

Doctors' Communication and Patient Engagement: This category includes adult and child CAHPS composites and HEDIS measures related to patient satisfaction with providers and patient engagement.

Access to Preventive Care: This category consists of CAHPS composites and HEDIS measures related to adults' and children's access to preventive care.

Women's Health: This category consists of HEDIS measures related to screenings for women and maternal health.

Living With Illness: This category consists of HEDIS measures related to diabetes, and cardiovascular and respiratory conditions.

Behavioral Health: This category consists of HEDIS measures related to follow-up care for behavioral health, as well as appropriate care for adults and children on antipsychotics.

Medication Management: This category consists of HEDIS measures related to antibiotic stewardship; and medication management for opioid use and behavioral health conditions.

HSAG computed six reporting category summary scores for the MCO. HSAG compared each measure to national benchmarks and assigned star ratings for each measure. HSAG used the following methodology to assign a star rating for each individual measure:

Table A-15—Measure Rate Star Rating Descriptions

Rating	MCO Measure Rate Performance Compared to National Benchmarks
★★★★★	The MCO's measure rate was at or above the national Medicaid 90th percentile
★★★★	The MCO's measure rate was between the national Medicaid 75th and 89th percentiles
★★★	The MCO's measure rate was between the national Medicaid 50th and 74th percentiles
★★	The MCO's measure rate was between the national Medicaid 25th and 49th percentiles
★	The MCO's measure rate was below the national Medicaid 25th percentile

[A-9] National Committee for Quality Assurance. "Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports for Consumers." October 1998.

In instances where data was missing (i.e., the audit designation was *Not Reported [NR], Biased Rate [BR],* or *Not Applicable [NA]*), HSAG handled the missing rates for measures as follows:

Rates with an *NR* designation were assigned 1-star.

Rates with a *BR* designation were assigned 1-star.

Rates with an *NA* designation resulted in the removal of that measure.

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

A five-level rating scale provides consumers with an easy-to-read "picture" of quality performance for the MCO and presents data in a meaningful manner. The MCO Scorecard uses stars to display MCO performance as follows:

Table A-16—MCO Scorecard Performance Ratings

Rating	MCO Performance Compared to National Benchmarks	
★★★★★	**Highest Performance**	The MCO's average performance was at or above the national Medicaid 90th percentile
★★★★	**High Performance**	The MCO's average performance was between the national Medicaid 75th and 89th percentiles
★★★	**Average Performance**	The MCO's average performance was between the national Medicaid 50th and 74th percentiles
★★	**Low Performance**	The MCO's average performance was between the national Medicaid 25th and 49th percentiles
★	**Lowest Performance**	The MCO's average performance was below the national Medicaid 25th percentile

Description of Data Obtained and Related Time Period

HSAG analyzed MY 2021 HEDIS results, including MY 2021 CAHPS data from two MCOs, Amerigroup and Iowa Total Care, for presentation in the 2022 Iowa Medicaid Scorecard.