STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Calendar Year 2023 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 (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 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) 2023 are displayed in Table 1-1.

Table 1-1—MCPs* in Iowa

MCO Name (MCO Short Name)	MCO Abbreviation
Amerigroup Iowa, Inc. (**Amerigroup**)[1-1]	**AGP**
Iowa Total Care, Inc. (**Iowa Total Care**)	**ITC**
Molina Healthcare of Iowa, Inc. (**Molina of Iowa**)[1-2]	**MOL**
PAHP Name (PAHP Short Name)	**PAHP Abbreviation**
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

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[1-1] Effective January 1, 2024, **Amerigroup Iowa, Inc.** (**Amerigroup**/**AGP**) rebranded to **Wellpoint Iowa, Inc.** (**WLP**). However, as **Amerigroup**/**AGP** was the existing name of the MCO during CY 2023, **Amerigroup**/**AGP** is referenced throughout.

[1-2] **Molina of Iowa** began providing coverage to Medicaid and Hawki members effective July 1, 2023.

Medicare & Medicaid Services (CMS).[1-3] 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 2023 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 components of network adequacy in alignment with the priorities of the State.	Protocol 4. Validation of Network Adequacy*
Encounter Data Validation (EDV)	The activity validates the accuracy and completeness of encounter data submitted by an MCP.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-4] 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 was mandatory effective February 2024 with the creation of CMS' EQR Protocol 4. HSAG's approach to conducting NAV activities in CY 2023 was tailored to address the specific needs of HHS by focusing on areas selected by HHS to assess network adequacy. Future NAV activities will be conducted in full alignment with Protocol 4 and will be included in the EQR technical report in CY 2025 as required by CMS.

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

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 1, 2024.

[1-4] 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 2023 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 the Iowa Medicaid Managed Care Quality Assurance System (MCO Quality Strategy) and the Iowa Medicaid Pre-Paid Ambulatory (PAHP) Dental Quality Strategy Plan (PAHP Quality Strategy) and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members.

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

Quality Strategy Goal Program Area	Overall Performance Impact	Performance Domain
Behavioral Health	**Conclusions:** Through the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-5] results, the Iowa Managed Care Program demonstrated that members seen in the emergency department (ED) and hospitalized for mental illness were receiving timely follow-up care, as all rates ranked at or above the 90th percentile for the *Follow-Up After ED Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness* measures. These results support HHS' MCO Quality Strategy goal: *Promote behavioral health by measuring follow-up after hospitalization/follow-up after emergency department visit (FUH/FUM) for pediatric and adult populations* and indicate that the MCOs implemented policies, procedures, and care coordination processes to ensure members received appropriate follow-up services after an ED visit or hospitalization for mental illness. However, for adult members who have co-occurring physical and mental health diagnoses (i.e., diabetes and schizophrenia or diabetes and bipolar disorder) and children and adolescents prescribed antipsychotics, HEDIS results indicate opportunities for the Iowa Managed Care Program to focus efforts on improving the management of these conditions. **Recommendations:** Due to the success of the behavioral health-related pay-for-performance measure (i.e., *Follow-Up After Hospitalization for Mental Illness*), HHS should consider expanding or replacing its existing pay-for-performance measures to include one or more of the lower-performing HEDIS measures	☒ Quality ☒ Timeliness ☒ Access

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

Quality Strategy Goal Program Area	Overall Performance Impact	Performance Domain
	(e.g., *Metabolic Monitoring for Children and Adolescents on Antipsychotics*). Additionally, or alternatively, HHS could mandate the MCOs to conduct a PIP that focuses on improving the management of children and adolescents on antipsychotics and/or adults who have co-occurring physical and mental health diagnoses. Further, HHS' existing MCO Quality Strategy does not include measurable performance metrics for most goals. Therefore, HHS should establish minimum performance standards or performance thresholds for each behavioral health -related goal and objective. Establishing a statewide performance benchmark will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress in meeting HHS' established MCO Quality Strategy goals and objectives. Finally, HHS should require calculation of the mandatory CMS Core Set measures by MCO. HHS could accomplish this by requiring its MCOs to calculate and report on each mandatory Core Set measure or contract with its existing vendor to calculate each mandatory Core Set measure by MCO, in addition to calculating the statewide aggregate rates for each measure.	
Access to Care **Improving Coordinated Care**	**Conclusions:** Based on HEDIS results, many adult and child members were accessing preventive medical care, as indicated by most applicable measure rates under the Access to Preventive Care and Keeping Kids Healthy domains performing at or above the national Medicaid 50th percentile. HEDIS results, as indicated by performance at or above the national Medicaid 50th percentile, also indicated that many child and adolescent members were receiving recommended immunizations. Additionally, as indicated through performance under the Women's Health domain, many adult and adolescent women were getting screened for breast cancer and/or cervical cancer, and under the Keeping Kids Healthy domain, many children were getting lead screenings as recommended. Further, under the Living With Illness domain, performance measure rates indicated that many members with diabetes and hypertension were being managed appropriately, as indicated by performance at or above the national Medicaid 50th percentile. These positive results indicate that members were able to access providers to obtain services, which was supported by positive member experiences (i.e., performance at or above 82.7 percent) in the *Getting Needed Care* and *Getting Care Quickly* statewide adult and child CAHPS results. These results also support that progress was made toward the Iowa Managed Care Program achieving the objective to *increase access to primary care and specialty care*. HHS also required the MCOs to develop a PIP that focused on timeliness of postpartum care. As indicated by the statewide rate	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal Program Area	Overall Performance Impact	Performance Domain
	for the *Prenatal and Postpartum Care—Postpartum Care* measure, the Iowa Managed Care Program is performing at or above the national Medicaid 50th percentile, indicating that women who had recently delivered were following up in a timely manner with their providers. Timely and adequate postpartum care can support positive health outcomes for new mothers and their infants. This higher performance also supports the Iowa Managed Care Program's progress toward achieving the *improve timeliness of postpartum care* objective under the Access to Care goal and the *improve the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes* objectives under the Improving Coordinated Care goal. However, there are opportunities to improve the number of members accessing preventive dental care, as 71.57 percent of DWP Adults, 46.28 percent of DWP Kids, and 61.21 percent of Hawki members obtained preventive dental services. Results of the NAV secret shopper survey activity indicated that only 39 percent of dental providers accepted new patients, and new patients had an average wait time of 61 days to get a cleaning appointment. These results may suggest that there were barriers to members accessing preventive dental services. The Iowa Managed Care Program's improvement in this program area will support progress toward achieving Goal 1 to *improve network adequacy and availability of services* and Goal 2 to *increase recall and preventive services*. **Recommendations:** As HHS has separate and distinct quality strategies for the MCOs and PAHPs, to support integration of the medical and dental programs, HSAG continues to recommend that HHS consider combining its separate quality strategies to include all programs supported by the MCOs and PAHPs. Additionally, HHS' existing MCO Quality Strategy does not include measurable performance metrics for most goals. Therefore, HHS should establish minimum performance standards or performance thresholds for each access and coordinated care-related goal and objective. Establishing a statewide performance benchmark will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress in meeting HHS' established MCO Quality Strategy goals and objectives. Further, HHS should focus improvement efforts with the PAHPs on the selected dental measures to advance Goal 1 and Goal 2 of the PAHP Quality Strategy to ensure that the DWP and Hawki programs meet HHS' CY 2024 goals. HHS could consider providing the PAHPs with the case-level data files and a timeline for each PAHP to address discrepancies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone	

Quality Strategy Goal Program Area	Overall Performance Impact	Performance Domain
	numbers and addresses, PAHP and Iowa Medicaid acceptance, new patient acceptance, and/or provider specialty information). Also, in addition to updating provider information, HHS should require the PAHPs to conduct a root cause analysis to identify the cause for the data discrepancies, and HHS should consider requiring the PAHPs to conduct a review of the offices' eligibility verification requirements to ensure that any barriers identified do not hinder members' ability to access dental care. Finally, HHS should require its PAHPs and its MCOs to conduct routine secret shopper surveys of their provider networks to assess compliance with network adequacy and appointment availability standards.	
Voice of the Customer	**Conclusions:** The MCOs obtained CAHPS vendors to administer the CAHPS survey annually in support of HHS' Voice of the Customer Goal and specifically, to *annually review the CAHPS results and make recommendations for improvements*. Based on the statewide results of the CAHPS survey, the adult Medicaid population reported positive experiences in *Getting Needed Care* and *Customer Service*, as these scores (85.3 percent and 92.2 percent, respectively) were statistically significantly higher than the 2022 NCQA Adult Medicaid national average. For the child Medicaid population, the scores for *Getting Needed Care* and *Getting Care Quickly* were both statistically significantly higher than the 2022 NCQA Child Medicaid national average, with scores of 88.4 percent and 90.1 percent, respectively. However, for the adult Medicaid population, the top-box score for *Rating of Specialist Seen Most Often* was 60.9 percent and had a statistically significant decline, which suggests that some members may have been deterred from going to their specialists for care based on their negative personal experiences. Additionally, the top-box scores for *Discussing Cessation Medications* for the adult population and *Rating of All Health Care* for the child population were statistically significantly lower than the 2022 national average, indicating that additional opportunities exist for improving member experience in these areas. In addition to annually reviewing the CAHPS results, HHS also required the MCOs to conduct a PIP with the topic *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed.* Both MCOs received an overall validation rating of *Met*, indicating the MCOs conducted appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement, although both MCOs had a statistically significant decline in performance from the baseline measurement rate for CY 2023.	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal Program Area	Overall Performance Impact	Performance Domain
	Recommendations: HHS' existing MCO Quality Strategy does not include measurable objectives that promote performance improvement. Therefore, HHS should establish minimum performance standards or performance thresholds for each Voice of the Customer-related objective. For example, HHS could set minimum performance standards for specific areas or domains of the CAHPS survey. Establishing a statewide performance benchmark will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress toward meeting HHS' established MCO Quality Strategy goals and objectives. Additionally, as HHS' PAHP Quality Strategy does not specifically address member experience, HHS could consider setting a PAHP performance objective under the Voice of the Customer overarching goal. HHS could also consider requiring the PAHPs to contract with a CAHPS vendor to administer a CAHPS survey that has been modified to address dental care.	
Health Equity	**Conclusions:** The CY 2023 EQR activity results (i.e., PIP, PMV, compliance review, NAV, EDV, and CAHPS) did not produce data to comprehensively evaluate the Iowa Managed Care Program's performance impact on health equity with the MCOs in support of the Health Equity goal within the MCO Quality Strategy or the PAHPs in support of Goal 3, *improve oral health equity among Medicaid members*, of the PAHP Quality Strategy. **Recommendations:** HHS' existing MCO Quality Strategy does not include measurable objectives that promote performance improvement. Therefore, HHS should establish objectives with minimum performance standards or performance thresholds that address health equity and target specific program areas where inequities are identified. HHS could also consider requiring a health equity focus for the next cycle of new PIPs for both the MCOs and PAHPs.	☒ Quality ☐ Timeliness ☐ Access

2. Overview of the Iowa Managed Care Program

Managed Care in Iowa

Since April 2016, most Medicaid recipients in Iowa receive benefits through a CMS-approved section 1915(b) waiver program called the Iowa High Quality Healthcare Initiative (Initiative). The Initiative also includes §1915(c) waiver and §1115 demonstration recipients and operates statewide. MCOs are contracted by HHS to deliver all medically necessary, Medicaid-covered physical health, behavioral health, and LTSS benefits in a highly coordinated manner. HHS also contracts with PAHPs to deliver dental benefits to members enrolled in the DWP and Hawki program.[2-1]

Overview of Managed Care Plans (MCPs)

During the CY 2023 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	257,380	• 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	243,918		
MOL	174,828		

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

[2-2] Iowa Department of Health and Human Services, Iowa Medicaid. Enrollment data provided by HHS on Mar 8, 2024.

[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 29, 2024.

PAHPs[2-1]	Total Enrollment[2-4]	Covered Services[2-5,2-6]	Service Area
DDIA	460,384	- Diagnostic and Preventive Services (exams, cleanings, x-rays, and fluoride) - Fillings for Cavities - Surgical and Non-Surgical Gum Treatment - Root Canals - Dentures and Crowns - Extractions	Statewide
MCNA	229,935		

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

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

MCP		Enrollment Population	Enrollment Count	Total Enrollment
MCOs	**AGP**	Medicaid	237,232	**676,126**
		Hawki	20,148	
		Total	**257,380**	
	ITC	Medicaid	223,144	
		Hawki	20,774	
		Total	**243,918**	
	MOL	Medicaid	160,945	
		Hawki	13,883	
		Total	**174,828**	

[2-4] Iowa Department of Health and Human Services, Iowa Medicaid. Enrollment data provided by HHS on Mar 8, 2024.

[2-5] State of Iowa Department of Health and Human Services. Dental Wellness Plan. Available at: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/dental-wellness-plan. Accessed on: Feb 1, 2024.

[2-6] State of Iowa Department of Health and Human Services. Hawki. Available at: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki-chip. Accessed on: Feb 1, 2024.

[2-7] Iowa Department of Health and Human Services, Iowa Medicaid. Enrollment data provided by HHS on Mar 8, 2024

MCP		Enrollment Population	Enrollment Count	Total Enrollment
PAHPs	**DDIA**	DWP Adults	223,926	**690,319**
		DWP Kids	173,735	
		Hawki	62,723	
		Total	**460,384**	
	MCNA	DWP Adults	129,394	
		DWP Kids	100,541	
		Hawki	NA*	
		Total	**229,935**	

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

Quality Strategy

The MCO Quality Strategy and the PAHP Quality Strategy[2-8,2-9] outline 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 MCO Quality Strategy and the PAHP Quality Strategy, respectively.

Table 2-3—Iowa Medicaid MCO Quality Strategy

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.

[2-8] Iowa Department of Human Services. Iowa Medicaid Managed Care Quality Assurance System, 2021. Available at: https://publications.iowa.gov/38789/1/2021_Iowa_Managed_Care_Quality_Plan.pdf. Accessed on: Jan 23, 2024.

[2-9] Iowa Department of Human Services Iowa Medicaid Enterprise. Iowa Medicaid Dental Pre-Ambulatory Health Plan (PAHP) Quality Strategy Plan, June 2023. Available at: https://hhs.iowa.gov/media/9022/download?inline=. Accessed on: Jan 23, 2024.

Quality Strategy Goals
• 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.
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 PAHP Quality Strategy

Quality Strategy Goals
• Goal 1.0–Improve Network Adequacy and Availability of Services – Objective 1.1: Increase the number of general dentists who actively see patients in the dental program – Objective 1.2: Increase the number of members who access any dental care in the year –
• Goal 2.0–Improve Prevention and Recall Dental Services to Improve Overall Health – Objective 2.1: Members who received preventive dental care – Objective 2.2: Continued preventive utilization – Objective 2.3: Members who received two topical fluoride applications – Objective 2.4: Members who received a dental sealant – Objective 2.5: Members who received a dental sealant on all four molars by age 10 – Objective 2.6: Increase the percentage of enrolled adults aged 30 years and older with a history of periodontitis who receive maintenance care
• Goal 3.0–Improve Oral Health Equity Among Medicaid Members – Objective 3.1: Monitor dental access by race, ethnicity, age, and gender – Objective 3.2: Increase race and ethnicity and social determinants of health reporting among the DWP population – Objective 3.3: Increase benefit utilization for special populations – Objective 3.4: Increase access for special populations
• Goal 4.0–Improve Coordination and Continuity of Care Between MCOs and dental PAHPs – Objective 4.1: Decrease the number of adult members who accessed the emergency department for non-traumatic, preventable dental conditions – Objective 4.2: Increase adult members who receive follow-up dental services after emergency department visits for non-traumatic, preventive dental conditions within 7 days and 30 days – Objective 4.3: Decrease child members who accessed emergency department for caries-related reasons – Objective 4.4: Increase the number of child members who receive follow-up dental services after emergency department visits for of caries-related reasons within 7 days and 30 days – Objective 4.5: Members who receive a topical fluoride application during a well-child visit

Quality Initiatives

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

Health Equity Plans by MCOs: The MCOs continue to provide quarterly updates on their health equity plans to the Quality Committee. The work the MCOs do around health equity aligns with the Iowa Medicaid MCO Quality Strategy. **Amerigroup** reduced the prevalence of babies born with low birth weights through this work. **Iowa Total Care** improved data capture for race/ethnicity by using Health Risk Assessment data. Both initiatives are part of the Medicaid Innovation Collaborative (MIC) project to reduce transportation barriers for diabetes in three counties. Work is still needed to see a measurable impact on the Iowa Managed Care Program populations.

Medicaid Enterprise Modernization Effort (MEME) Project: The MEME project continued in 2023. This large, multi-year information technology (IT) systems and business process modernization is focused on achieving outcomes that align with the Medicaid strategic priorities. Having a focus on measurable outcomes (e.g., shortening the time required to approve an application) can generate dramatically improved results compared to requirements-based IT procurement approaches from the past. This also aligns with the CMS move to streamlined modular certification that likewise shifts to an outcomes-based mindset.

Iowa is seeking to deliver value and learning in incremental steps to demonstrate that implementation is tracking to match the intent of investments in IT. Empowerment of delivery teams, incorporation of end user input, and transparency are also included. Iowa is beginning by implementing a module intended to deliver better provider outcomes through an improved, modernized enrollment process. HHS expects some providers to see value through the modernized enrollment process beginning as early as the fall of 2024.

Hope and Opportunity in Many Environments (HOME) Project: Iowa Medicaid currently supports seven Medicaid waivers; however, this approach fails to adequately support Iowans in the goal of living in the community of their choice. HOME will redesign Iowa's waiver and HCBS system to improve access to high-quality behavioral health, disability, and aging services. To achieve this, HHS collaborated with Mathematica and The Harkin Institute to conduct an evaluation of community-based services and publish a final evaluation report in early 2023. Throughout 2023, HHS explored meaningful system transformation requirements, finalized fiscal analysis research questions, and created the framework for waiver redesign. By March 2024, HHS will have an implementation plan for required case management ratios. By June 2024, HHS will complete the Needs on Waitlist (NOW) survey. By August 2024, HHS will have an updated waiver package available for public comment.

3. Assessment of Managed Care Organization Performance

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2023 review period to evaluate the performance of MCOs on providing quality, timely, and accessible healthcare services to Iowa Managed Care Program members. Quality, as it pertains to EQR, means the degree to which the MCOs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to HHS' network adequacy standards) and §438.206 (adherence to HHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the MCOs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in CY 2023 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For the CY 2023 validation, two MCOs (**Amerigroup** and **Iowa Total Care**)[3-1] continued their HHS mandated clinical PIP topic, *Timeliness of Postpartum Care*, and the nonclinical PIP topic, *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*, reporting Remeasurement 2 data for the performance indicators. HSAG conducted validation of the Implementation (Step 7—Review the Data Analysis and Interpretation of PIP Results and Step 8—Assess the Improvement Strategies) and Outcomes (Step 9—Assess the Likelihood that Significant and Sustained Improvement Occurred) stages for each PIP topic. 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**[3-2] for measurement year (MY) 2022 (January 1, 2022–December 31, 2022) to validate claims and encounter data processing procedures that contribute to CMS Core Set reporting. HSAG also validated data integration and measure production processes of an HHS vendor, IBM Watson (IBM),

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[3-1] **Molina of Iowa** began providing coverage to Medicaid and Hawki members effective July 1, 2023; therefore, no data were available to display in Table 3-1. **Molina of Iowa**'s PIPs will be reported in the CY 2024 EQR technical report.

[3-2] **Molina of Iowa** began providing coverage to Medicaid and Hawki members effective July 1, 2023; therefore, no performance measure data were available for the SFY 2023 PMV activity. **Molina of Iowa**'s PMV results will be reported in the CY 2024 EQR technical report.

that is contracted with HHS to provide aggregate performance measure rates for all Medicaid populations for CMS Core Set reporting.

Table 3-2 shows the list of performance measures and measurement periods evaluated for MY 2022 for the CY 2023 PMV activity.

Table 3-2—Performance Measures for Validation

Performance Measure Name and Indicator	Measure Source
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	HEDIS, CMS Child Core Set
Ages 3 Months–17 Years	
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	HEDIS, CMS Child Core Set
Initiation Phase	
Continuation and Maintenance Phase	
Ambulatory Care	HEDIS, CMS Child Core Set
Emergency Department (ED) Visits	
Antidepressant Medication Management	HEDIS, CMS Adult and Child Core Set
Effective Acute Phase Treatment—Ages 18–64 Years	
Effective Acute Phase Treatment—Ages 65 and Older	
Effective Continuation Phase Treatment—Ages 18–64 Years	
Effective Continuation Phase Treatment—Ages 65 and Older	
Asthma Medication Ratio	HEDIS, CMS Child Core Set
Ages 5–11 Years	
Ages 12–18 Years	
Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS, CMS Child Core Set
Blood Glucose and Cholesterol Testing—Total	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	HEDIS, CMS Child Core Set
Screening for Depression and Follow-Up Plan	CMS Adult Core Set
Ages 18–64 Years	
Ages 65 and Older	
Screening for Depression and Follow-Up Plan	CMS Child Core Set
Ages 12–17 Years	
Chlamydia Screening in Women	HEDIS, CMS Child Core Set
Ages 16–20 Years	
Childhood Immunization Status	HEDIS, CMS Child Core Set
Combination 3	
Combination 7	
Combination 10	

Performance Measure Name and Indicator	Measure Source
Developmental Screening in the First Three Years of Life—Total	CMS Child Core Set
Follow-Up After Emergency Department Visit for Substance Use	HEDIS, CMS Adult and Child Core Set
7-Day Follow-Up—Ages 13–17 Years	
30-Day Follow-Up—Ages 13–17 Years	
7-Day Follow-Up—Ages 18–64 Years	
30-Day Follow-Up—Ages 18–64 Years	
7-Day Follow-Up—Ages 65 and Older	
30-Day Follow-Up—Ages 65 and Older	
Follow-Up After Hospitalization for Mental Illness	HEDIS, CMS Adult and Child Core Set
7-Day Follow-Up—Ages 6–17 Years	
30-Day Follow-Up—Ages 6–17 Years	
7-Day Follow-Up—Ages 18–64 Years	
30-Day Follow-Up—Ages 18–64 Years	
7-Day Follow-Up—Ages 65 and Older	
30-Day Follow-Up—Ages 65 and Older	
Follow-Up After Emergency Department Visit for Mental Illness	HEDIS, CMS Adult and Child Core Set
7-Day Follow-Up—Ages 6–17 Years	
30-Day Follow-Up—Ages 6–17 Years	
7-Day Follow-Up—Ages 18–64 Years	
30-Day Follow-Up—Ages 18–64 Years	
7-Day Follow-Up—Ages 65 and Older	
30-Day Follow-Up—Ages 65 and Older	
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set
Ages 18–64 Years	
Ages 65–75 Years	
Initiation and Engagement of Substance Use Disorder Treatment	HEDIS, CMS Adult Core Set
Initiation of SUD Treatment—Total	
Engagement of SUD Treatment—Total	
Immunizations for Adolescents	HEDIS, CMS Child Core Set
Combination 1	
Combination 2	
Lead Screening in Children	HEDIS, CMS Child Core Set
Use of Pharmacotherapy for Opioid Use Disorder—Total	CMS Adult Core Set
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	HEDIS, CMS Adult Core Set

Performance Measure Name and Indicator	Measure Source
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS, CMS Adult Core Set
Well-Child Visits in the First 30 Months	HEDIS, CMS Child Core Set
Well-Child Visits in the First 15 Months	
Well-Child Visits for Age 15 Months–30 Months	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	HEDIS, CMS Child Core Set
Body Mass Index (BMI) Percentile Documentation—Total	
Counseling for Nutrition—Total	
Counseling for Physical Activity—Total	
Child and Adolescent Well-Care Visits—Total	HEDIS, CMS Child Core Set

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

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

Table 3-3—HEDIS Measures

HEDIS Measure by Domain of Care
Access to Preventive Care
Adults' Access to Preventive/Ambulatory Health Services
Ages 20–44 Years
Ages 45–64 Years
Ages 65 and Older
Use of Imaging Studies for Low Back Pain
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
BMI Percentile Documentation—Total
Counseling for Nutrition—Total
Counseling for Physical Activity—Total
Women's Health
Breast Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women—Total
Non-Recommended Cervical Cancer Screening in Adolescent Females
Prenatal and Postpartum Care
Timeliness of Prenatal Care

HEDIS Measure by Domain of Care
Postpartum Care
Living With Illness
Hemoglobin A1c Control for Patients With Diabetes
HbA1c Control (<8%)
HbA1c Poor Control (>9.0%)
Blood Pressure Control for Patients With Diabetes
Blood Pressure Control (<140/90 mm Hg)
Eye Exam for Patients With Diabetes
Eye Exam (Retinal) Performed
Controlling High Blood Pressure
Statin Therapy for Patients With Cardiovascular Disease
Received Statin Therapy—Total
Statin Therapy for Patients With Diabetes
Received Statin Therapy
Behavioral Health
Diabetes Monitoring for People With Diabetes and Schizophrenia
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Follow-Up After Emergency Department (ED) Visit for Substance Use
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Follow-Up After ED Visit for Mental Illness
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Initiation and Engagement of Substance Use Disorder (SUD) Treatment
Initiation of SUD Treatment—Total
Engagement of SUD Treatment—Total
Metabolic Monitoring for Children and Adolescents on Antipsychotics
Blood Glucose and Cholesterol Testing—Total
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total
Keeping Kids Healthy
Child and Adolescent Well-Care Visits—Total
Childhood Immunization Status

HEDIS Measure by Domain of Care
Combination 3
Combination 10
Immunizations for Adolescents
Combination 1
Combination 2
Lead Screening in Children
Well-Child Visits in the First 30 Months of Life
Well-Child Visits in the First 15 Months
Well-Child Visits for Age 15 Months–30 Months
Medication Management
Adherence to Antipsychotic Medications for Individuals With Schizophrenia
Antidepressant Medication Management
Effective Acute Phase Treatment
Effective Continuation Phase Treatment
Appropriate Testing for Pharyngitis—Total
Appropriate Treatment for Upper Respiratory Infection—Total
Asthma Medication Ratio-Total
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
Initiation Phase
Continuation and Maintenance Phase
Persistence of Beta-Blocker Treatment After a Heart Attack
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
Systemic Corticosteroid
Bronchodilator
Statin Therapy for Patients With Cardiovascular Disease
Statin Adherence 80%—Total
Statin Therapy for Patients With Diabetes
Statin Adherence 80%—Total
Use of Opioids at High Dosage
Use of Opioids From Multiple Providers
Multiple Prescribers
Multiple Pharmacies
Multiple Prescribers and Multiple Pharmacies

Compliance Review

HHS requires its contracted MCOs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet mandatory EQR requirements. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The current three-year compliance review cycle was initiated in CY 2021 and comprised 14 program areas referred to as standards. At HHS's direction, HSAG conducted a review of the first seven federally required standards and requirements in Year One (CY 2021) and a review of the remaining federally required seven standards and requirements in Year Two (CY 2022) of the three-year compliance review cycle. This CY 2023 (Year Three) compliance review activity, which included **Amerigroup** and **Iowa Total Care**,[1-3] consisted of a re-review of the standards that were not fully compliant during the CY 2021 (Year One) and CY 2022 (Year Two) compliance review activities, as indicated by the elements (i.e., requirements) that received *Not Met* scores and required corrective action plans (CAPs) to remediate the noted deficiencies. Table 3-4 outlines the standards reviewed over the three-year review cycle.

Table 3-4—Compliance Review Standards

Standard	Associated Federal Citation[1]		Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of each MCO's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b)	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1110 §457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	

[3-3] **Molina of Iowa** began providing coverage to Medicaid and Hawki members effective July 1, 2023; therefore, the SFY 2023 CAP compliance review activity was not applicable to **Molina of Iowa**. **Molina of Iowa** will be included in the CY 2024 compliance review activity, which begins a new three-year cycle of reviews, and reported in the CY 2024 EQR technical report.

Standard	Associated Federal Citation[1]		Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
	Medicaid	CHIP			
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240(b)		✓	

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

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

Network Adequacy Validation

In CY 2023, HSAG conducted and completed NAV activities for two MCOs—**Amerigroup** and **Iowa Total Care**[3-4]. The NAV activities included an assessment of the following dimensions of behavioral health care utilization:

- **Percentage of behavioral health providers with new pediatric patients:** This dimension assessed the number of contracted behavioral health providers in the measurement year (CY 2022) with visits from one or more pediatric members who did not have a behavioral health visit in the lookback year (CY 2021) and the percentage of all behavioral health providers that had such visits. Results were tabulated separately for inpatient and outpatient providers.
- **Average number of new pediatric patients among behavioral health providers:** This dimension evaluated the distribution of new pediatric members seen by contracted behavioral health providers and the average (mean) and median numbers of new members per provider as summary measures. Results were tabulated separately for inpatient and outpatient providers.
- **Percentage of members that are new pediatric behavioral health patients:** This dimension assessed the number and percentage of pediatric members with new behavioral health visits during the measurement year compared with members with visits in both years, those with visits only in the lookback year, and those with no visits in either year.
- **Geographic and demographic characteristics of new pediatric behavioral health patients:** This dimension showed tabulations of new patient status by members' urban/rural residential location, race, ethnicity, and sex, with comparisons between pediatric members with new behavioral health visits during the measurement year and members with visits in both years, those with visits only in the lookback year, and those with no visits in either year.

[3-4] **Molina of Iowa** began providing coverage to Medicaid and Hawki members effective July 1, 2023; therefore, no data were available for the CY 2023 NAV activity. **Molina of Iowa**'s NAV results will be reported in the CY 2024 EQR technical report.

Encounter Data Validation

In CY 2023, HSAG conducted and completed EDV activities for the three MCOs (i.e., **Amerigroup**, **Iowa Total Care**, and **Molina of Iowa**). The EDV activities included:

- Information systems (IS) review—assessment of the MCOs' information systems and processes. The goal of this activity is to examine the extent to which the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data.
- Targeted comparative analysis—analysis of HHS' electronic encounter data completeness and accuracy through a comparison between HHS' electronic encounter data and the data extracted from the MCOs' data systems. The goal of this activity is to evaluate the extent to which the encounter data in HHS' data warehouse that were submitted by the MCOs are complete and accurate. Additionally, the analysis targets an evaluation of a known provider enrollment issue that would have affected the accuracy and completeness of HHS' encounter data. The analysis seeks to identify the gap(s) as a result of the issue.

Molina of Iowa began administering benefits and providing services to Iowa Managed Care Program members on July 1, 2023. Therefore, since CY 2023 was the first year **Molina of Iowa** submitted encounter data to HHS, HSAG conducted an IS review with this MCO in CY 2023. For **Amerigroup** and **Iowa Total Care**, HSAG had previously conducted an IS review (i.e., in CY 2016 and CY 2019, respectively). As such, HSAG did not conduct an IS review for these MCOs in CY 2023. HSAG had conducted an administrative profile analysis, comparative analysis, and a medical record review in prior years for both **Amerigroup** and **Iowa Total Care**. Due to HHS' concerns regarding known provider enrollment issues and their potential impact on the accuracy and completeness of submitted encounters, HSAG conducted a targeted comparative analysis to evaluate the extent to which encounters within HHS' data warehouse were being affected by this issue.

Consumer Assessment of Healthcare Providers and Systems Analysis

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. Two MCOs, **Amerigroup** and **Iowa Total Care**,[3-5] 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.

[3-5] **Molina of Iowa** began providing coverage to Medicaid and Hawki members effective July 1, 2023; therefore, the MCO did not conduct CAHPS during CY 2023.

Table 3-5—CAHPS Measures of Member Experience

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

Scorecard

HSAG analyzed MY 2022 HEDIS results and MY 2022 CAHPS data from the two MCOs, **Amerigroup** and **Iowa Total Care**, for presentation in the 2023 Iowa Medicaid Scorecard.[3-6] 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.

[3-6] A third MCO, **Molina of Iowa**, was not included in the analysis as the MCO was new in calendar year 2023 and did not have reportable MY 2022 data.

- **Women's Health:** This category consists of HEDIS measures related to screenings for women and maternal health.
- **Living With Illness:** This category consists of HEDIS measures related to diabetes, cardiovascular, and respiratory conditions.
- **Behavioral Health:** This category consists of HEDIS measures related to follow-up care for behavioral health, as well as appropriate care for adults on antidepressants and antipsychotics, and children on antipsychotics and medications for attention-deficit/hyperactivity disorder (ADHD).
- **Medication Management:** This category consists of HEDIS measures related to antibiotic stewardship, as well as medication management for opioid use and behavioral health conditions.

HSAG computed six reporting category summary scores 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 Implementation and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-6 displays the overall validation rating and the baseline, Remeasurement 1, and Remeasurement 2 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
Clinical PIP: *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% ↑	82.6% ↑
Nonclinical PIP: *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% ⇔	70.5% ↓

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (*p* value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (*p* value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (*p* value < 0.05)
* The PIP activities for CY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for CY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

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 barriers identified through quality improvement (QI) and causal/barrier analysis processes and the interventions initiated by the MCO to support achievement of the PIP goals and address the barriers.

Table 3-7—Remeasurement 2 Barriers and Interventions for AGP

Timeliness of Postpartum Care	
Barriers	**Interventions**
Members have not completed their postpartum visit.	Telephonic outreach calls to eligible members who need a postpartum visit.
	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.
The enterprise HEDIS team was unable to retrieve 100 percent of requested medical records from provider sites.	Identify key provider sites to request remote access to their electronic medical record during the annual HEDIS hybrid project.
CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	
Barriers	**Interventions**
Member's dissatisfaction with customer service experience. Member not given accurate information.	Manager audits post call survey alert calls and provides coaching, feedback, and additional training to customer service representatives.
Customer service provided inaccurate or incomplete information.	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.

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 sustained statistically significant improvement over the baseline performance for the *Timeliness of Postpartum Care* PIP topic for the second remeasurement period. **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: Amerigroup demonstrated a statistically significant decline in performance from the baseline measurement period for the *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed* PIP. **[Quality and Access]**

Why the weakness exists: While it is unclear why the performance indicator demonstrated a significant decrease in performance, the data suggest that barriers exist for members in the receipt of information or help from the MCO.

Recommendation: HSAG recommends that **Amerigroup** revisit its causal/barrier analysis to determine if any new barriers exist that require the development of targeted strategies to improve performance.

Performance Measure Validation

Performance Results

PMV

HSAG reviewed **Amerigroup**'s eligibility and enrollment data and its claims and encounter data, which included live demonstrations of each system. Validated rates and performance measure designations, listed at an aggregate level for all MCOs and Medicaid populations using the MCOs' encounter submissions and Fee-for-Service (FFS) data, are provided in the Managed Care Plan Comparative Information section of this report.

Overall, **Amerigroup** demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, and report accurate encounter data to HHS. HSAG did not identify any significant concerns with **Amerigroup**'s processes.

HEDIS

HSAG's review of the Final Audit Report (FAR) for HEDIS MY 2022 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 2022. **Amerigroup** contracted with an external software vendor with HEDIS Certified Measures^{SM} for measure production and rate calculation.

Table 3-8—HEDIS MY 2022 Results for AGP

Measures	HEDIS 2020 (MY 2020) Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Three-Year Trend	Star Rating
Access to Preventive Care					
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	80.59%	79.78%	77.91%	↓	★★★
45–64 Years	85.27%	85.53%	84.36%	↓	★★★
65 Years and Older	78.06%	89.64%	91.71%	↑	★★★★
Use of Imaging Studies for Low Back Pain					
Use of Imaging Studies for Low Back Pain	—	—	69.97%	—	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile Documentation—Total	72.02%	71.78%	81.19%	↑	★★★
Counseling for Nutrition—Total	65.69%	64.96%	69.59%	↑	★★
Counseling for Physical Activity—Total	61.07%	62.53%	66.75%	↑	★★
Women's Health					
Breast Cancer Screening					
Breast Cancer Screening	53.59%	52.72%	53.32%	↓	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	60.10%	59.12%	61.56%	↑	★★★
Chlamydia Screening in Women					
Total	44.86%	45.22%	46.68%	↑	★
Non-Recommended Cervical Cancer Screening in Adolescent Females*					
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.21%	0.27%	0.18%	↑	★★★★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	78.10%	81.51%	89.51%	↑	★★★★
Postpartum Care	68.86%	76.89%	82.62%	↑	★★★★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
HbA1c Control (<8%)	46.47%	48.42%	62.29%	↑	★★★★★
*HbA1c Poor Control (>9.0%)**	42.34%	42.34%	27.49%	↑	★★★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control (<140/90 mm Hg)	72.26%	71.29%	77.86%	↑	★★★★★

Measures	HEDIS 2020 (MY 2020) Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Three-Year Trend	Star Rating
Eye Exam for Patients With Diabetes					
Eye Exam (Retinal) Performed	55.47%	54.99%	59.37%	↑	★★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	65.69%	64.23%	68.13%	↑	★★★★
Statin Therapy for Patients With Cardiovascular Disease					
Received Statin Therapy—Total	81.21%	80.24%	81.24%	↑	★★★
Statin Therapy for Patients With Diabetes					
Received Statin Therapy	68.81%	66.53%	65.21%	↓	★★
Behavioral Health					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	70.55%	72.32%	72.16%	↑	★★★
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	74.63%	79.11%	78.08%	↑	★★
Follow-Up After Emergency Department Visit for Substance Use					
7 Day Follow-Up—Total	—	—	59.35%	—	NC
30 Day Follow-Up—Total	—	—	69.09%	—	NC
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—Total	64.60%	67.10%	65.45%	↑	★★★★★
30-Day Follow-Up—Total	75.90%	77.99%	76.06%	↑	★★★★★
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	48.83%	57.61%	63.54%	↑	★★★★★
30-Day Follow-Up—Total	69.37%	75.50%	79.03%	↑	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment					
Initiation of SUD Treatment—Total	—	—	65.28%	—	NC
Engagement of SUD Treatment—Total	—	—	24.17%	—	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose and Cholesterol Testing–Total	23.12%	24.68%	26.29%	↑	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	58.96%	62.73%	62.92%	↑	★★★
Keeping Kids Healthy					
Childhood Immunization Status					
Combination 3	75.43%	73.24%	71.78%	↓	★★★★
Combination 10	51.58%	49.15%	42.09%	↓	★★★★

Measures	HEDIS 2020 (MY 2020) Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Three-Year Trend	Star Rating
Immunizations for Adolescents					
Combination 1	88.81%	85.89%	83.94%	↓	★★★
Combination 2	31.39%	35.77%	35.77%	↑	★★★
Lead Screening in Children					
Lead Screening in Children	82.00%	77.62%	73.72%	↓	★★★★
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%	62.75%	↑	★★★★
Well-Child Visits for Age 15 Months—30 Months—Two or More Well-Child Visits	70.09%	70.08%	68.46%	↓	★★★
Child and Adolescent Well-Care Visits					
Total	45.54%	49.75%	49.65%	↑	★★★
Medication Management					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.62%	64.67%	64.78%	↓	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	52.94%	60.15%	62.38%	↑	★★★
Effective Continuation Phase Treatment	37.41%	42.52%	44.24%	↑	★★★
Appropriate Testing for Pharyngitis					
Total	80.59%	78.09%	80.61%	↑	★★★★★
Appropriate Treatment for Upper Respiratory Infection					
Total	85.99%	90.21%	89.71%	↑	★★
Asthma Medication Ratio					
Total	66.94%	70.27%	67.36%	↑	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Total	47.06%	46.65%	56.12%	↑	★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	42.87%	43.41%	49.29%	↑	★★★★
Continuation and Maintenance Phase	45.50%	47.83%	53.55%	↑	★★★
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	78.28%	81.19%	83.68%	↑	★★★
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	74.41%	72.33%	75.21%	↑	★★★
Bronchodilator	83.39%	81.67%	79.66%	↓	★
Statin Therapy for Patients With Cardiovascular Disease					
Statin Adherence 80%—Total	72.84%	69.30%	71.71%	↓	★★★

Measures	HEDIS 2020 (MY 2020) Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Three-Year Trend	Star Rating
Statin Therapy for Patients With Diabetes					
Statin Adherence 80%—Total	70.34%	68.86%	69.92%	↓	★★★
Use of Opioids at High Dosage*					
Use of Opioids at High Dosage	2.64%	2.07%	2.34%	↑	★★★
Use of Opioids From Multiple Providers*					
Multiple Prescribers	16.59%	18.27%	17.09%	↓	★★★
Multiple Pharmacies	1.40%	1.07%	1.24%	↑	★★★★
Multiple Prescribers and Multiple Pharmacies	1.04%	0.81%	0.88%	↑	★★★

* For this indicator, a lower rate indicates better performance.
—This symbol indicates that NCQA recommended a break in trending; therefore, the rate is not displayed.
"NC" indicates that NCQA recommended a break in trending; therefore, the rate could not be compared to the national Medicaid MY 2021 benchmarks.
↓ Indicates performance worsened over a three-year time period.
↑ Indicates performance improved over a three-year time period.
HEDIS MY 2022 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★= At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Amerigroup demonstrated multiple methods of validation and tracking to ensure accuracy of claim conversion into encounter files for submission to HHS. Further, **Amerigroup**'s reporting dashboard allowed for weekly review of claims for remediation prior to encounter conversion. [**Quality**]

Strength #2: Amerigroup's performance in the Living With Illness domain improved notably this year in several areas. The *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)*, *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*, and *Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)* indicator rates all improved substantially from the prior year's rates to finish at or above the 90th percentile. The *Eye Exam for Patients With Diabetes—Eye Exam (Retinal) Performed* indicator and the *Controlling High Blood Pressure* measure both demonstrated increases of approximately 4 percentage points, finishing at or above the 75th percentile. [**Quality**]

Strength #3: Amerigroup's performance in the Behavioral Health domain demonstrated an upward three-year trend for all measures with a comparable rate from prior years. The *Follow-Up After ED Visit for Mental Illness—7–Day Follow-Up—Total*, *Follow-Up After ED Visit for Mental Illness—30–Day Follow-Up—Total*, *Follow-Up After Hospitalization for Mental Illness—7–Day Follow-Up—Total*, and *Follow-Up After Hospitalization for Mental Illness—30–Day Follow-Up—Total* indicators demonstrated the highest performance, finishing MY 2022 with rates at or above the 90th 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 percentage of women were not being seen or screened by their providers. Untreated chlamydia infections can lead to serious and irreversible complications. [**Quality**]

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** previously conducted an educational campaign with providers and determined that providers were following national standards, it appears that women in this age range were still not comfortable reporting sexual activity to their provider or experienced barriers accessing the appropriate services for screening completion.

Recommendation: HSAG recommends that **Amerigroup** continue its work with providers on educational efforts, as materials may be most effective when distributed by providers in conjunction with office visits. Additionally, HSAG recommends that **Amerigroup** conduct further analysis to evaluate whether particular racial/ethnic groups have a significantly different rate for accessing care. Upon identification of a root cause, **Amerigroup** should implement appropriate interventions (contracting efforts, transportation assistance, care coordination, etc.) to improve the low performance rate for the *Chlamydia Screening in Women* measure.

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

Recommendation: HSAG recommends that **Amerigroup** continue partnering with providers to determine why some members with severe mental illnesses are not being monitored for diabetes or for metabolic functioning, such as by providing education when needed to ensure behavioral health providers understand which tests to monitor and how to access lab testing. **Amerigroup** should continue to work with providers and care coordination teams to implement appropriate interventions (e.g., process improvements, patient education campaigns, etc.) to improve the performance rate of this measure.

Compliance Review

Performance Results

Table 3-9 presents an overview of the results of the CY 2021 and CY 2022 compliance reviews for **Amerigroup**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements (i.e., requirements) it reviewed. If a requirement was not applicable to **Amerigroup** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

Table 3-9—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
Standard II—Member Rights and Member Information	20	20	16	4	0	**80%**
Standard III—Emergency and Poststabilization Services	10	10	10	0	0	**100%**
Standard IV—Availability of Services	9	9	9	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	5	5	5	0	0	**100%**
Standard VI—Coordination and Continuity of Care	10	10	9	1	0	**90%**
Standard VII—Coverage and Authorization of Services	10	10	8	2	0	**80%**
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 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	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard XIV—Quality Assessment and Performance Improvement Program	30	30	28	2	0	**93%**
Total	**193**	**193**	**173**	**20**	**0**	**90%**

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

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

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

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

[1] This standard includes a comprehensive assessment of the MCO's IS capabilities.

Based on the findings of the CY 2021 and CY 2022 compliance review activities, **Amerigroup** was required to develop and submit a CAP for each element assigned a score of *Not Met*. HHS and HSAG reviewed the CAP for sufficiency, and **Amerigroup** was responsible for implementing each action plan in a timely manner. Table 3-10 presents an overview of the results of the CY 2023 compliance review for **Amerigroup**, which consisted of a comprehensive review of the MCO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-10—Summary of CAP Implementation

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard II—Member Rights and Member Information	4	2	**2**
Standard VI—Coordination and Continuity of Care	1	1	**0**
Standard VII—Coverage and Authorization of Services	2	1	**1**
Standard VIII—Provider Selection	3	3	**0**
Standard IX—Confidentiality	1	1	**0**
Standard X—Grievance and Appeal Systems	5	4	**1**
Standard XI—Subcontractual Relationships and Delegation	2	2	**0**
Standard XIV—Quality Assessment and Performance Improvement Program	2	2	**0**
Total	**20**	**16**	**4**

Total CAP Elements: The total number of elements within each standard that required a CAP during the CY 2021 and CY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

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 demonstrated that it successfully remediated 16 of 20 elements, indicating the necessary policies, procedures, and initiatives were implemented and demonstrated compliance with the requirements under review. Further, **Amerigroup** remediated all elements for five of the eight standards reviewed: Coordination and Continuity of Care, Provider Selection, Confidentiality, Subcontractual Relationships and Delegation, and Quality Assessment and Performance Improvement Program. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Amerigroup did not remediate two of the four CAP elements for the Member Rights and Member Information standard, indicating continued gaps in the MCO's processes to ensure all member materials were available and provided in Spanish and that the provider directory included all required information. [**Quality** and **Timeliness**]

Why the weakness exists: Although **Amerigroup** provided examples of written materials in Spanish, implementation of a Spanish translation for all of **Amerigroup**'s written materials had been delayed. Additionally, **Amerigroup** provided one provider example within its paper and online provider directories that displayed information specifically related to accessibility equipment for members with disabilities, confirming that **Amerigroup** had the capability to include this information in the provider directly. However, HSAG was unable to locate any other provider listings within the directory that included specific accessibility information. While **Amerigroup** provided copies of credentialing applications, the applications did not appear to include a place for providers to document availability of any special equipment for members with disabilities.

Recommendation: HSAG required **Amerigroup** to submit an action plan to address the deficiencies and provide assurances that all member materials were translated in Spanish and that **Amerigroup** developed a methodology and outreach plan to collect accessibility data from its network providers and demonstrate significant progress in updating the provider directory with specific accessibility indicators. HSAG recommends that **Amerigroup** conduct periodic oversight and monitoring processes to ensure that the actions taken have been fully implemented.

Weakness #2: Amerigroup did not remediate one CAP element under the Coverage and Authorization standard, indicating continued gaps in the MCO's processes for issuing an adverse benefit determination (ABD) for payment denials.

Why the weakness exists: Although **Amerigroup** demonstrated that efforts have been made to develop a list of claim denial codes that will trigger an ABD, the list of codes had not been finalized, and the process to send an ABD based on these codes had not been implemented. Additionally, the MCO confirmed that the Iowa Medicaid MCOs were working collectively to determine the most appropriate ABD notice template to use consistently across the Medicaid program. Of note, the ABD template that the MCO submitted was appropriate and met the intent of the federal rule; however, the MCO indicated that implementation of the denial of payment ABD process would not occur until 90 days following the collective decision on the type of communication that will be sent to members.

Recommendation: HSAG recommends that **Amerigroup** proceed with its existing plans of action to implement the ABD for denial of payment process to comply with the federal rule.

Weakness #3: **Amerigroup** did not remediate one element under the Grievance and Appeal Systems standard, indicating continued gaps in the MCO's appeal processes, as the MCO continued to inappropriately require a written appeal.

Why the weakness exists: While the MCO revised its ABD notice template to remove language requiring members to submit a written appeal request following an oral request for an appeal, the ABD template had not been implemented at the time of the site review. This deficiency was also identified during a prior compliance review.

Recommendation: HSAG recommends that **Amerigroup** proceed with its existing plans of action to implement the revised ABD template and update its processes to not require written appeals following oral requests to ensure the MCO comes into compliance with this requirement.

Network Adequacy Validation

Performance Results

Table 3-11 presents the percentage of behavioral health providers with new pediatric behavioral health visits in 2022 for **Amerigroup**, across the Medicaid and Hawki programs, and in total. Please note that the Medicaid and Hawki programs utilize the same networks of contracted providers.

Table 3-11—Percentage of Behavioral Health Providers With Pediatric New Member Visits in 2022

		Medicaid	Hawki	Total
MCO and Provider Type	Total Number of Providers	Number (Percent) of Providers With New Member Visits	Number (Percent) of Providers With New Member Visits	Number (Percent) of Providers With New Member Visits
All Providers	4,850	1,185 (24.4%)	483 (10.0%)	1,260 (26.0%)
Inpatient Providers	52	20 (38.5%)	9 (17.3%)	21 (40.4%)
Outpatient Providers	4,798	1,165 (24.3%)	474 (9.9%)	1,239 (25.8%)

Note: Pediatric members are ages 18 years and under with continuous enrollment in Medicaid and/or Hawki in 2021 and 2022. Behavioral health visits are defined as visits with a behavioral health provider. A new member visit is defined as a visit with any behavioral health provider in 2022 for members who had no behavioral health visits in 2021. **Amerigroup** has the same provider network for Medicaid and Hawki. For this reason, the total number of providers is the same for Medicaid, Hawki, and overall. The total number of providers with new visits across lines of business (LOBs) may be smaller than the sum of Medicaid providers with new visits and Hawki providers with new visits because each provider may have new member visits in both LOBs, and these providers should not be double counted.

Table 3-12 presents the average number of pediatric new member visits in 2022 for all behavioral health providers, inpatient providers only, and outpatient providers only in the **Amerigroup** provider networks. The table is limited to providers with at least one new member visit.

Table 3-12—Average Number of Pediatric New Member Visits for Behavioral Health Providers in 2022

Provider Category and LOB	Number of Providers With New Member Visits	Number of New Member Visits	Average Number of New Member Visits	Median Number of New Member Visits	Number of New Member Visits, 25th and 75th Percentiles
All Providers					
Hawki	483	1,737	3.6	1.0	1.0–2.0
Medicaid	1,185	10,787	9.1	2.0	1.0–6.0
Total	1,260	12,524	9.9	2.0	1.0–6.0
Inpatient Providers					
Hawki	9	812	90.2	2.0	1.0–3.0
Medicaid	20	4,812	240.6	9.0	1.5–29.0
Total	21	5,624	267.8	11.0	2.0–25.0
Outpatient Providers					
Hawki	474	925	2.0	1.0	1.0–2.0
Medicaid	1,165	5,975	5.1	2.0	1.0–6.0
Total	1,239	6,900	5.6	2.0	1.0–6.0

Note: Pediatric members are ages 18 years and under with continuous enrollment in Medicaid and/or Hawki in 2021 and 2022. Behavioral health visits are defined as visits with a behavioral health provider. A new member visit is defined as a visit with any behavioral health provider in 2022 for members who had no behavioral health visits in 2021. **Amerigroup** has the same provider network for Medicaid and Hawki. For this reason, the total number of providers is the same for Medicaid, Hawki, and overall. The total number of providers with new visits across LOBs may be smaller than the sum of Medicaid providers with new visits and Hawki providers with new visits because each provider may have new member visits in both LOBs, and these providers should not be double counted. The average, median, and percentile statistics were calculated for providers with at least one new member visit in 2022 only.

Table 3-13 and Table 3-14 present the demographic and geographic characteristics of **Amerigroup** pediatric members with behavioral health visits in 2021 and 2022, for Medicaid and Hawki, respectively.

Table 3-13—Demographic and Geographic Characteristics of AGP Medicaid Pediatric Members With Behavioral Health Visits in 2021 and 2022

Characteristic	Number (Percent) With New Visits in 2022	Number (Percent) With Visits in 2021 Only	Number (Percent) With Visits in Both Years	Number (Percent) With No Visits in Either Year
Age				
5 Years and Under	2,162 (5.8%)	1,592 (4.3%)	2,941 (7.9%)	30,732 (82.1%)
6 to 12 Years	4,170 (6.7%)	3,106 (5.0%)	7,906 (12.7%)	46,973 (75.6%)

Characteristic	Number (Percent) With New Visits in 2022	Number (Percent) With Visits in 2021 Only	Number (Percent) With Visits in Both Years	Number (Percent) With No Visits in Either Year
13 to 18 Years	3,945 (7.7%)	3,686 (7.2%)	8,865 (17.3%)	34,687 (67.8%)
Race/Ethnicity				
Hispanic*	1,112 (5.8%)	889 (4.6%)	2,071 (10.8%)	15,172 (78.8%)
White	4,234 (7.6%)	3,669 (6.5%)	8,697 (15.5%)	39,418 (70.4%)
Black or African American	677 (6.3%)	525 (4.9%)	1,407 (13.1%)	8,159 (75.8%)
American Indian or Alaska Native	53 (7.7%)	44 (6.4%)	96 (13.9%)	499 (72.1%)
Asian	90 (4.1%)	60 (2.7%)	126 (5.7%)	1,931 (87.5%)
Native Hawaiian and Other Pacific Islander	42 (4.4%)	29 (3.1%)	82 (8.6%)	795 (83.9%)
Two or More Races	374 (8.1%)	293 (6.3%)	642 (13.9%)	3,315 (71.7%)
Unknown	3,695 (6.6%)	2,875 (5.1%)	6,591 (11.7%)	43,103 (76.6%)
Sex				
Female	5,122 (7.0%)	3,985 (5.4%)	9,260 (12.7%)	54,822 (74.9%)
Male	5,155 (6.6%)	4,399 (5.7%)	10,452 (13.5%)	57,570 (74.2%)
Urbanicity**				
Rural	3,979 (6.5%)	3,477 (5.7%)	7,091 (11.7%)	46,239 (76.1%)
Urban	6,298 (7.0%)	4,907 (5.5%)	12,621 (14.0%)	66,153 (73.5%)

* Members identified as Hispanic can be of any race or combination of races. All other categories excluding Unknown are non-Hispanic.
** Members with a residential address in a county defined as a Metropolitan Statistical Area are living in an urban area; all other members live in rural areas.
Note: Pediatric members are ages 18 years and under with continuous enrollment in Medicaid and/or Hawki in 2021 and 2022. Behavioral health visits are defined as visits with a behavioral health provider. A new visit is defined as a visit with any behavioral health provider in 2022 for members who had no behavioral health visits in 2021.

Table 3-14—Demographic and Geographic Characteristics of AGP Hawki Pediatric Members With Behavioral Health Visits in 2021 and 2022

Characteristic	Number (Percent) With New Visits in 2022	Number (Percent) With Visits in 2021 Only	Number (Percent) With Visits in Both Years	Number (Percent) With No Visits in Either Year
Age				
5 Years and Under	266 (5.3%)	159 (3.2%)	274 (5.5%)	4,328 (86.1%)
6 to 12 Years	700 (6.0%)	431 (3.7%)	1,047 (9.0%)	9,519 (81.4%)
13 to 18 Years	699 (6.6%)	595 (5.7%)	1,360 (12.9%)	7,858 (74.8%)

Characteristic	Number (Percent) With New Visits in 2022	Number (Percent) With Visits in 2021 Only	Number (Percent) With Visits in Both Years	Number (Percent) With No Visits in Either Year
Race/Ethnicity				
Hispanic*	137 (5.0%)	110 (4.0%)	170 (6.3%)	2,301 (84.7%)
White	818 (6.5%)	596 (4.7%)	1,422 (11.3%)	9,800 (77.6%)
Black or African American	63 (6.9%)	38 (4.1%)	102 (11.1%)	713 (77.8%)
American Indian or Alaska Native	13 (10.6%)	4 (3.3%)	17 (13.8%)	89 (72.4%)
Asian	14 (3.0%)	12 (2.6%)	16 (3.5%)	419 (90.9%)
Native Hawaiian and Other Pacific Islander	32 (6.9%)	24 (5.1%)	63 (13.5%)	348 (74.5%)
Two or More Races	35 (6.1%)	33 (5.8%)	70 (12.3%)	433 (75.8%)
Unknown	553 (5.9%)	368 (3.9%)	821 (8.8%)	7,602 (81.4%)
Sex				
Female	849 (6.4%)	592 (4.4%)	1,354 (10.2%)	10,538 (79.0%)
Male	816 (5.9%)	593 (4.3%)	1,327 (9.5%)	11,167 (80.3%)
Urbanicity**				
Rural	698 (5.5%)	520 (4.1%)	1,021 (8.0%)	10,567 (82.5%)
Urban	967 (6.7%)	665 (4.6%)	1,660 (11.5%)	11,138 (77.2%)

* Members identified as Hispanic can be of any race or combination of races. All other categories excluding Unknown are non-Hispanic.
** Members with a residential address in a county defined as a Metropolitan Statistical Area are living in an urban area; all other members live in rural areas.
Note: Pediatric members are ages 18 years and under with continuous enrollment in Medicaid and/or Hawki in 2021 and 2022. Behavioral health visits are defined as visits with a behavioral health provider. A new visit is defined as a visit with any behavioral health provider in 2022 for members who had no behavioral health visits in 2021.

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: Twenty-six percent of **Amerigroup** behavioral health providers had a visit with at least one new pediatric member in CY 2022, indicating that some members looking for new behavioral health services were able to obtain services.

Weaknesses and Recommendations

Weakness #1: 74 percent of **Amerigroup** behavioral health providers did not have a visit with at least one new pediatric member in CY 2022.

Why the weakness exists: This could be due to either a lack of provider willingness to accept new behavioral health pediatric patients or a limited number of new pediatric patients requiring these services.

Recommendation: HSAG recommends combining the findings from this analysis with member experience reports to determine if there may be an access issue for pediatric patients seeking new behavioral health services. The results of this analysis, along with member experience and grievance information, can help **Amerigroup** assess whether this represents adequate access or a potential network adequacy concern for pediatric members seeking behavioral health services.

Encounter Data Validation

Performance Results—Targeted Comparative Analysis

Table 3-15 displays the percentage of records present in the files submitted by **Amerigroup** 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 **Amerigroup** (record surplus) by encounter type (i.e., institutional and professional). **Lower rates indicate better performance for both record omission and record surplus**.

Table 3-15—Record Omission and Surplus, by Encounter Type

Encounter Data Type	Record Omission	Record Surplus
Professional	2.3%	1.5%
Institutional	1.5%	0.1%

Table 3-16 and Table 3-17 display the results for key data elements related to professional and institutional encounter types, respectively. These tables include information on element omission, element surplus, element missing values, and element accuracy. **For the element omission and surplus indicators, lower rates indicate better performance. For the element accuracy indicator, higher rates indicate better performance.** However, for the element missing values indicator, lower or higher rates do not indicate better or worse performance.

Table 3-16—Data Element Omission, Surplus, Missing Values, and Accuracy: Professional Encounters

Key Data Element	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
Member ID	0.0%	0.0%	0.0%	100.0%
Detail Service From Date	0.0%	0.0%	0.0%	100.0%
Detail Service To Date	0.0%	0.0%	0.0%	100.0%

Key Data Element	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
Billing Provider NPI	0.0%	0.0%	0.0%	100.0%
Billing Provider ZIP Code	<0.1%	0.0%	0.0%	70.4%
Billing Provider Taxonomy Code	0.0%	0.0%	21.4%	100.0%
Rendering Provider NPI	0.0%	0.0%	0.0%	99.8%
Referring Provider NPI	0.0%	1.9%	59.0%	100.0%
Primary Diagnosis Code	0.0%	0.0%	0.0%	100.0%
Procedure Code[5] (CDT, CPT, HCPCS)	0.0%	0.0%	0.0%	100.0%
Procedure Code Modifier[6]	0.0%	0.0%	54.4%	100.0%
Units of Service	0.0%	0.0%	0.0%	>99.9%

[1] Element Omission displays the percentage of records with values present in the **Amerigroup**'s submitted files but not in HHS' submitted files.

[2] Element Surplus displays the percentage of records with values present in HHS' submitted files but not in the **Amerigroup**'s submitted files.

[3] Element Missing Values displays the percentage of records with values missing from both HHS' submitted files and **Amerigroup**'s submitted files.

[4] Element Accuracy displays the percentage of records with the values present and having identical values in both **Amerigroup**'s submitted files and HHS' submitted files.

[5] Current Dental Terminology [CDT], Current Procedural Terminology [CPT], or Healthcare Common Procedure Coding System [HCPCS] code.

[6] Only the first procedure code modifier was assessed for the comparative analysis.

Table 3-17—Data Element Omission, Surplus, Missing Values, and Accuracy: Institutional Encounters

Key Data Element	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
Member ID	0.0%	0.0%	0.0%	100.0%
Header Service From Date	0.0%	0.0%	0.0%	100.0%
Header Service To Date	0.0%	0.0%	0.0%	100.0%
Billing Provider NPI	0.0%	0.0%	0.0%	100.0%
Billing Provider ZIP Code	<0.1%	0.0%	0.0%	95.0%
Billing Provider Taxonomy Code	0.0%	0.0%	2.5%	100.0%
Attending Provider NPI	0.0%	0.0%	<0.1%	100.0%
Referring Provider NPI	0.0%	0.0%	96.6%	100.0%
Primary Diagnosis Code	0.0%	0.0%	0.0%	96.0%
Procedure Code[5] (CDT, CPT, HCPCS)	0.1%	0.0%	14.8%	100.0%

Key Data Element	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
Procedure Code Modifier[6]	0.0%	0.0%	75.3%	100.0%
Units of Service	0.0%	0.0%	0.0%	100.0%
Surgical Procedure Codes[7]	0.0%	1.6%	95.4%	0.0%

[1] Element Omission displays the percentage of records with values present in the **Amerigroup**'s submitted files but not in HHS' submitted files.

[2] Element Surplus displays the percentage of records with values present in HHS' submitted files but not in the **Amerigroup**'s submitted files.

[3] Element Missing Values displays the percentage of records with values missing from both HHS' submitted files and **Amerigroup**'s submitted files.

[4] Element Accuracy displays the percentage of records with the values present and having identical values in both **Amerigroup**'s submitted files and HHS' submitted files.

[5] Current Dental Terminology [CDT], Current Procedural Terminology [CPT], or Healthcare Common Procedure Coding System [HCPCS] code.

[6] Only the first procedure code modifier was assessed for the comparative analysis.

[7] All submitted surgical procedure codes were ordered and concatenated as a single data element for the comparative analysis.

Table 3-18 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing or non-missing) for all key data elements relevant to each encounter data type.

Table 3-18—All Element Accuracy, by Encounter Type

Encounter Data Type	All Element Accuracy
Professional	68.4%
Institutional	13.7%

Note: The denominator for the all-element accuracy rate is defined differently from the denominators for the individual element accuracy rates since it includes data elements even if values are missing in both sources. If any of the data elements are an element omission, element surplus, or an inaccurate value match, the record will not be a positive hit for the all-element accuracy numerator.

Table 3-19 displays the percentage of legacy provider numbers in HHS' data that were not populated for professional and institutional encounters.

Table 3-19—Legacy Billing Provider Numbers Not Populated, by Encounter Type

Encounter Data Type	Legacy Billing Provider Numbers Not Populated
Professional	<0.1%
Institutional	<0.1%

Table 3-20 displays the percentage of legacy billing provider numbers in HHS' data that were populated for professional and institutional encounters, but key provider information did not match between HHS' and **Amerigroup**'s data sources. The rate was calculated only when the values were present in both data sources. If at least one of the values was missing in either data source, then they were not included in the denominator.

Table 3-20—Legacy Billing Provider Number Populated, by Encounter Type

Encounter Data Type	ZIP Codes Did Not Match	Taxonomy Did Not Match
Professional	29.6%	0.0%
Institutional	5.0%	0.0%

Table 3-21 illustrates the percentage of legacy billing provider numbers in HHS' data that were populated for professional encounters, with HSAG confirming the provider type by place of service (POS), CPT, or both. The process to verify whether the provider type (derived from the legacy billing provider number) aligns with the services rendered on the claims data involved the following steps:

- Using the legacy billing provider number populated in the HHS-submitted encounter data, HSAG extracted the associated provider type from the HHS-submitted provider data.
- HSAG evaluated the assignment of these provider types, considering data elements from the encounter data such as POS, CPT codes, type of bill (TOB), and revenue codes.
- Data elements were grouped, and a subjective verification was conducted to ensure alignment with the assigned provider type.

Table 3-21—Legacy Billing Provider Type Validation by POS and CPT: Professional Encounters

Provider Type Matched Services on Claim on POS Only	Provider Type Matched Services on Claim on CPT Only	Provider Type Matched Services on Claim on Both POS and CPT
98.6%	99.3%	98.1%

Table 3-22 illustrates the percentage of legacy billing provider numbers in HHS' data that were populated for institutional encounters, with HSAG confirming the provider type by TOB, revenue code, CPT, or all three. For matching based on all three fields, the numerator and denominator were calculated when all fields were populated with non-missing values. The process to verify whether the provider type aligns with the services rendered on the claims data is the same process as described above for the professional encounter types.

Table 3-22—Legacy Billing Provider Type Validation by TOB, Revenue Code, and CPT: Institutional Encounters

Provider Type Matched Services on Claim on TOB Only	Provider Type Matched Services on Claim on Revenue Code Only	Provider Type Matched Services on Claim on CPT Only	Provider Type Matched Services on Claim on TOB, Revenue Code, and CPT
97.6%	>99.9%	>99.9%	97.2%

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: Amerigroup's professional and institutional encounters exhibited complete data with low record omission and record surplus rates. [**Quality**]

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

Weaknesses and Recommendations

Weakness #1: Amerigroup had low accuracy rates for the *Billing Provider ZIP Code* data element for professional encounters. [**Quality**]

Why the weakness exists: Based on its data discrepancy report response, **Amerigroup** sourced the billing provider address from a different data source than HHS, resulting in reduced accuracy for the *Billing Provider ZIP Code* data element.

Recommendation: HSAG recommends that **Amerigroup** work with HHS to ensure that provider data are sourced from the same or a similar platform.

Weakness #2: The data element accuracy rate for *Surgical Procedure Codes* for **Amerigroup** was 0.0 percent. [**Quality**]

Why the weakness exists: Based on its data discrepancy report response, **Amerigroup** noted that the programmatic script which creates surgical procedure codes did not have the correct conditions to check all qualifiers.

Recommendation: HSAG recommends that **Amerigroup** monitor and update programmatic scripts to ensure that all conditions are being met to submit complete and accurate data.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-23 presents **Amerigroup**'s CY 2023 adult Medicaid, general child Medicaid, and children with chronic conditions (CCC) Medicaid CAHPS top-box scores. Arrows (↓ or ↑) indicate CY 2023 scores that were statistically significantly higher or lower than the 2022 national average.

Table 3-23—Summary of CY 2023 CAHPS Top-Box Scores for AGP

	2023 Adult Medicaid	2023 General Child Medicaid	2023 CCC Medicaid Supplemental
Composite Measures			
Getting Needed Care	83.6%	89.7% ↑	88.0%
Getting Care Quickly	79.1%	90.9% ↑	93.4% ↑
How Well Doctors Communicate	90.9%	94.2%	96.1%
Customer Service	NA	NA	NA
Global Ratings			
Rating of All Health Care	58.3%	66.2%	63.3%
Rating of Personal Doctor	68.3%	78.2%	74.3%
Rating of Specialist Seen Most Often	59.5% ↓	NA	74.9%
Rating of Health Plan	54.4% ↓	71.5%	61.7% ↓
Medical Assistance With Smoking and Tobacco Use Cessation Items*			
Advising Smokers and Tobacco Users to Quit	69.9%	▨	▨
Discussing Cessation Medications	46.0%	▨	▨
Discussing Cessation Strategies	39.9%	▨	▨
CCC Composite Measures/Items			
Access to Specialized Services	▨	▨	76.4%
FCC: Personal Doctor Who Knows Child	▨	▨	89.5%
Coordination of Care for Children With Chronic Conditions	▨	▨	73.8%
Access to Prescription Medicines	▨	▨	92.0%
FCC: Getting Needed Information	▨	▨	92.2%

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."
* These scores follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 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 the care their child needed and getting care for their child quickly, as scores for the *Getting Needed Care* and *Getting Care Quickly* measures were statistically significantly higher than the 2022 NCQA child Medicaid national averages. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Parents/caretakers of child members in the CCC population had positive experiences with getting care for their child quickly, as the score for the *Getting Care Quickly* measure was statistically significantly higher than the 2022 NCQA CCC Medicaid national average. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Adult members had less positive overall experiences with the specialist they saw most often and their health plan, as scores for the *Rating of Specialist Seen Most Often* and *Rating of Health Plan* measures were statistically significantly lower than the 2022 NCQA adult Medicaid national averages. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicated that adult members may not be receiving the help they need from the specialists they see and that overall, they did not rate the care received from their health plan highly.

Recommendation: HSAG recommends that **Amerigroup** consider if any barriers exist to receiving timely care from specialists that may result in lower levels of experience or if there is a shortage of providers or certain specialists in the area. Additionally, **Amerigroup** may conduct root cause analyses or focus studies to determine why adult members are potentially perceiving a lack of overall quality of care from their health plan. Once a root cause or probable reasons for lower ratings are identified, **Amerigroup** can determine appropriate interventions, education, and actions to improve performance.

Weakness #2: Parents/caretakers of child members in the CCC population had less positive overall experiences with their child's health plan, as the score for the *Rating of Health Plan* measure was statistically significantly lower than the 2022 NCQA CCC Medicaid national average. [**Quality**]

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

Recommendation: HSAG recommends that **Amerigroup** conduct root cause analyses or focus studies to determine why parents/caretakers of child members in the CCC population are potentially perceiving a lack of overall quality of care from their child's health plan. Once a root cause or probable reasons for lower ratings are identified, **Amerigroup** can determine appropriate interventions, education, and actions to improve performance.

Scorecard

The 2023 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—MCO Comparative Information to review the 2023 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 MCO Quality Strategy goals and objectives. Table 3-24 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Amerigroup**'s Medicaid and Hawki members.

Table 3-24—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Behavioral Health	**Quality**, **Timeliness**, and **Access**—**Amerigroup** demonstrated strengths in managing behavioral health transitions of care through the PMV activity results. Specifically, **Amerigroup**'s HEDIS measure rates for the *Follow-Up After ED Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness* measures ranked at or above the 90th percentile, indicating that **Amerigroup** implemented policies, procedures, and care coordination processes to ensure members received appropriate follow-up services after an ED visit or hospitalization for mental illness. **Amerigroup**'s performance in this area positively impacts the goal to *Promote behavioral health by measuring follow-up after hospitalization/follow-up after emergency department visit (FUH/FUM) for pediatric and adult populations* as outlined in HHS' MCO Quality Strategy. However, as the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* rate had a slight decline from the prior year, **Amerigroup** should closely monitor this measure and implement additional interventions if a continued decline is observed. Additionally, the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* HEDIS measure rates indicated that there are opportunities for **Amerigroup** to implement interventions to address medication management for members with related behavioral health conditions, as both rates fell below the 50th percentile, with *Metabolic Monitoring for Children and Adolescents on Antipsychotics* ranking below the 25th percentile. **Amerigroup**

Performance Area	Overall Performance Impact
	demonstrated a slight improvement in the rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics* and reported several initiatives to address behavioral health performance measures. **Amerigroup** also reported that it is waiting for final approval of behavioral health mini-lab testing collaterals to share with providers and will continue to monitor performance improvement of this measure. 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. Further, utilization data were obtained through the NAV activity, which focused on an analysis of behavioral health providers who saw new pediatric patients during CY 2022. The results indicate that 26 percent of **Amerigroup**'s behavioral health providers had a visit with at least one new pediatric patient in CY 2022, indicating that some pediatric members looking for new behavioral health services were able to access services. Conversely, 74 percent of **Amerigroup**'s behavioral health providers did not have a visit with at least one new pediatric member in CY 2022. This could be a result of fewer new pediatric members requesting behavioral health services, or that the behavioral health provider is not accepting new behavioral health pediatric patients. Of importance, these utilization metrics are not indicative of better or worse performance, and further analysis would be needed to determine if potential access issues exist. **Amerigroup** should review the results of the NAV activity, conduct ongoing internal reviews of behavioral health utilization, and monitor for any barriers that may impede a new pediatric member from receiving behavioral health services.
Access to Care	**Quality**, **Timeliness**, and **Access**—Through HEDIS reporting, **Amerigroup** demonstrated both positive and negative results related to the MCO's impact on HHS' MCO Quality Strategy goals to *Improve timeliness of postpartum care* and *Increase access to primary care and specialty care* in the areas of Women's Health, Preventive Care, and Care for Chronic Conditions. • Women's Health—Women's Health domain measure rates indicated mixed results for female members receiving recommended health screenings. Specifically, the rates for *Cervical Cancer Screening, Chlamydia Screening in Women,* and *Non-Recommended Cervical Screening in Adolescent Females* demonstrated a three-year upward trend, although the *Chlamydia Screening in Women* rate fell below the 25th percentile and the *Breast Cancer Screening* rate demonstrated a three-year downward trend. The *Chlamydia Screening in Women* rate also performed lower in CY 2022. While **Amerigroup** reported that it will continue educational efforts with providers to include women's health and cultural competency, specific initiatives to address this measure are unclear.

Performance Area	Overall Performance Impact
	However, **Amerigroup** also demonstrated strength in women's health related to its members accessing prenatal and postpartum care, as the rates for *Timeliness of Prenatal Care* and *Postpartum Care* ranked at or above the 75th percentile but below the 90th percentile and had a three-year upward trend. Further, for the *Timeliness of Postpartum Care* PIP, **Amerigroup** demonstrated statistically significant improvement from the baseline rate (68.9 percent) to the Remeasurement 2 rate (82.6 percent), indicating that more 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. • Preventive Care—Similarly, for the Access to Preventive Care and Keeping Kids Healthy domains, **Amerigroup**'s rates also demonstrated mixed performance. Four of the six rates in the Access to Preventive Care domain demonstrated a three-year upward trend, and all eight rates within the Keeping Kids Healthy domain scored at or above the 50th percentile, with four of those rates at or above the 75th percentile but below the 90th percentile, indicating that more members were accessing preventive care, which could lower their risk for diseases, disabilities, and other negative health outcomes. While the Keeping Kids Health domain demonstrated higher performing rates overall, five rates showed a negative three-year trend. As such, **Amerigroup** should continue to monitor these measure rates and conduct an in-depth analysis of reasons for the decline should this trend continue. Additionally, while the *Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* rates under the Access to Preventive Care domain demonstrated a positive three-year upward trend, both rates were below the 50th percentile, indicating that opportunities for improvement continue to exist in providing counseling for nutrition and physical activity to children and adolescents. • Care for Chronic Conditions—**Amerigroup**'s members appear to have been accessing timely services to obtain disease-specific care (i.e., management of diabetes and hypertension) they needed to maintain optimal health, as indicated by higher-performing HEDIS rates in the Living With Illness domain. Six of the seven rates were at or above the 50th percentile, with two of those rates at or above the 75th percentile and three of those rates at or above the 90th percentile. Additionally, within the Medication Management domain, 16 of the 18 measure rates ranked at or above the 50th percentile, with two of those rates at or above the 75th percentile but below the 90th percentile and one measure rate at or above the 90th percentile, indicating that members were accessing care and providers were effectively treating many members' conditions through appropriate medication management. **Amerigroup** should focus efforts on the lower-performing measures within the Living With Illness and Medication Management domains;

Performance Area	Overall Performance Impact
	specifically, *Statin Therapy for Patients With Diabetes*, *Appropriate Treatment for Upper Respiratory Infection*, and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*. Further, member satisfaction with providers may affect a member's willingness to access primary or specialty care. The results of the CAHPS activity, which assesses member experiences with providers, demonstrated that more parents/caretakers of child members in the general population reported positive experiences in *Getting Needed Care* and *Getting Care Quickly*, and for the CCC population, more parents/caretakers reported positive experiences with *Getting Care Quickly,* as these scores were statistically significantly higher than the 2022 national average. However, for the adult Medicaid population, the score for *Rating of Specialist Seen Most Often* had a statistically significant decline, which could negatively impact members accessing care from a specialist who may be managing a chronic condition. **Amerigroup** should use the results of the CAHPS surveys to determine if there are additional barriers that are affecting members accessing needed care and develop specific interventions to address any identified barriers.
Voice of the Customer	**Quality**—Through the 2023 CAHPS activity, **Amerigroup** achieved scores that were statistically significantly higher than the 2022 national average in *Getting Needed Care* for the general child Medicaid survey and *Getting Care Quickly* for both child surveys. **Amerigroup**'s members reported that it was easy to obtain care, tests, or treatment, and were able to obtain care for illness or injury, and nonurgent appointments as soon as needed. However, the scores for *Rating of Specialist Seen Most Often* for adult Medicaid and *Rating of Health Plan* for the Medicaid CCC population were statistically significantly lower than the 2022 national averages, indicating that adult members had a less positive overall experience with the specialist they saw most often, and parents/caretakers of CCC had fewer positive experiences with their health plan. These results suggest that opportunities exist for **Amerigroup** to conduct further analysis of the potential barriers that may exist and contribute to members' dissatisfaction. **Amerigroup**'s *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*, as demonstrated through the PIP results, declined from the baseline rate of 84.3 percent and Remeasurement 1 rate of 92.9 percent to 70.5 percent for Remeasurement 2. **Amerigroup** identified barriers including member dissatisfaction with their customer service experience and/or that customer service representatives (CSRs) provided inaccurate or incomplete information. Although **Amerigroup** implemented interventions to address the identified barriers, including but not limited to manager audits of post-call survey alerts to provide coaching, feedback, and training to CSRs and to ensure that the information being provided to members was correct and up to date, these interventions appear to have

Performance Area	Overall Performance Impact
	been unsuccessful, as there was a statistically significant decline from the baseline measurement period. **Amerigroup** should continue to evaluate each intervention to determine effectiveness and use the evaluation process to determine if the intervention should be continued, revised, or discontinued. Further, through the compliance review activity, **Amerigroup** did not remediate two of the four elements for the Member Rights and Member Information standard, indicating continued gaps in the MCO's processes that ensured all written member materials were available in the State's prevalent languages and that the provider directory included all required information. In addition to **Amerigroup** ensuring that its CAP is fully implemented, **Amerigroup** should have processes to continually assess and improve member informational materials to ensure that members receive accurate and complete information, which may positively impact member satisfaction with **Amerigroup**.
Health Information Systems	**Quality**—Through the CY 2023 PMV activity, **Amerigroup** demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, and report accurate encounter data to HHS. HSAG did not identify any concerns with **Amerigroup**'s processes. **Amerigroup** demonstrated multiple methods of validation and tracking to ensure accuracy of claim conversion into encounter files for submission to HHS. Further, **Amerigroup**'s reporting dashboard allowed for weekly review of claims for remediation prior to encounter conversion. Finally, through the EDV activity, the encounters that **Amerigroup** submitted were relatively complete and accurate.

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 Implementation and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-25 displays the overall validation rating and baseline, Remeasurement 1, and Remeasurement 2 results for each PIP topic.

Table 3-25—Overall Validation Rating for ITC

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
Clinical PIP: *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% ⇔	77.9% ⇔
Nonclinical PIP: *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% ⇔	79.4% ↓

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)
* The PIP activities for CY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for CY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

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 3-26 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MCO to support achievement of the PIP goals and address the barriers.

Table 3-26—Remeasurement 1 Barriers and Interventions for ITC

Timeliness of Postpartum Care	
Barriers	**Interventions**
Member knowledge gap regarding available health plan programs and services.	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.
Low health literacy levels among members. Members may not understand the need for, or be aware of, a postpartum visit.	Automated text messages and mailed educational letters 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 for enrollment in the MCO's Start Smart for Baby (SSFB) program.
	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.
Lack of member engagement with healthcare and MCO as part of self-care.	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.
	Iowa Total Care implemented a doula pilot program for pregnant members living in Polk, Johnson, and Muscatine counties. The doula value add includes three visits while pregnant, in-person birthing support, and three visits after birth.

CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	
Barriers	**Interventions**
Lack of internal communication methods to disseminate information related to member programs or updates.	Updated internal employee communication methods to ensure timely dissemination of program materials. Updated internal communication processes allowed the MCO staff to provide members with up-to-date information. Internal survey for **Iowa Total Care** staff on which methods of communication would work best for them regarding changes or updates to health plan programs.
Limited front-line customer service knowledge regarding pharmacy benefits.	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. Surveyed Member Services agents to gather their feedback regarding the Pharmacy Microsoft SharePoint page resource.

CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	
Barriers	**Interventions**
Overuse of callbacks and/or transfers to get members needed information.	Used after-call surveys and quality checks to ensure agents are performing as expected. Staff from the Quality Improvement department listened to recordings from incoming calls to the Member Services department. There were opportunities for staff trainings and individualized education as needed.

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 1 percent from 2021 to 2022. Additionally, for the *Timeliness of Postpartum Care* PIP, provider education increased the number of pregnancy notifications submitted by providers to the MCO from 2021 to 2022. **[Quality, Timeliness, and Access]**

Weaknesses and Recommendations

Weakness #1: The *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed* PIP demonstrated a statistically significant decrease in performance compared to the baseline. **[Quality and Access]**

Why the weakness exists: While it is unclear why the performance indicator declined during the second remeasurement period, the data suggest that there are barriers within **Iowa Total Care**'s customer service department in providing information or help to members upon request.

Recommendation: HSAG recommends that **Iowa Total Care** revisit its causal barriers analysis to determine if any new barriers exist that require the development of targeted strategies to improve performance.

Performance Measure Validation

Performance Results

PMV

HSAG reviewed **Iowa Total Care**'s eligibility and enrollment data and its claims and encounter data, which included live demonstrations of each system. Validated rates and performance measure designations, listed at an aggregate level for all MCO and Medicaid populations using the MCOs' encounter submissions and FFS data, are provided in the Managed Care Plan Comparative Information section of this report.

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, and report accurate encounter data to HHS. HSAG did not identify any significant concerns with **Iowa Total Care**'s processes.

HEDIS

HSAG's review of the FAR for HEDIS MY 2022 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 2022. **Iowa Total Care** contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

Table 3-27—HEDIS MY 2022 Results for ITC

Measures	HEDIS 2020 (MY 2020) Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Three-Year Trend	Star Rating
Access to Preventive Care					
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	77.47%	78.84%	77.46%	↓	★★★
45–64 Years	85.78%	85.56%	83.91%	↓	★★★
65 Years and Older	81.78%	85.80%	84.62%	↑	★★★
Use of Imaging Studies for Low Back Pain					
Use of Imaging Studies for Low Back Pain	—	—	68.75%	—	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile Documentation—Total	69.83%	72.02%	70.07%	↑	★
Counseling for Nutrition—Total	61.56%	61.80%	58.39%	↓	★
Counseling for Physical Activity—Total	55.72%	58.15%	54.01%	↓	★

Measures	HEDIS 2020 (MY 2020) Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Three-Year Trend	Star Rating
Women's Health					
Breast Cancer Screening					
Breast Cancer Screening	NA	44.82%	49.61%	—	★★
Cervical Cancer Screening					
Cervical Cancer Screening	49.64%	55.72%	56.69%	↑	★★
Chlamydia Screening in Women					
Total	45.61%	48.67%	47.89%	↑	★
Non-Recommended Cervical Cancer Screening in Adolescent Females*					
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.61%	0.50%	0.48%	↑	★★★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	69.59%	75.43%	81.75%	↑	★★
Postpartum Care	72.51%	76.40%	77.86%	↑	★★★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
HbA1c Control (<8%)	38.93%	52.31%	48.42%	↑	★★
*HbA1c Poor Control (>9.0%)**	50.12%	39.90%	41.61%	↑	★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control (<140/90 mm Hg)	65.21%	69.34%	69.10%	↑	★★★★
Eye Exam for Patients With Diabetes					
Eye Exam (Retinal) Performed	51.82%	59.37%	56.69%	↑	★★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	62.53%	67.88%	61.07%	↓	★★★
Statin Therapy for Patients With Cardiovascular Disease					
Received Statin Therapy—Total	NA	62.03%	69.03%	—	★
Statin Therapy for Patients With Diabetes					
Received Statin Therapy	NA	50.19%	56.09%	—	★
Behavioral Health					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	43.47%	55.15%	58.06%	↑	★
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%	77.59%	↑	★★
Follow-Up After Emergency Department Visit for Substance Use					
7-Day Follow-Up—Total	—	—	56.74%	—	NC

Measures	HEDIS 2020 (MY 2020) Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Three-Year Trend	Star Rating
30-Day Follow-Up—Total	—	—	66.30%	—	NC
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—Total	61.36%	60.85%	63.69%	↑	★★★★★
30-Day Follow-Up—Total	72.48%	72.37%	75.03%	↑	★★★★★
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	30.72%	45.06%	52.84%	↑	★★★★
30-Day Follow-Up—Total	50.94%	66.00%	71.37%	↑	★★★★
Initiation and Engagement of Substance Use Disorder Treatment					
Initiation of SUD Treatment—Total	—	—	58.37%	—	NC
Engagement of SUD Treatment—Total	—	—	20.94%	—	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose and Cholesterol Testing–Total	20.76%	23.35%	24.76%	↑	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	59.16%	64.48%	61.74%	↑	★★
Keeping Kids Healthy					
Childhood Immunization Status					
Combination 3	70.07%	71.05%	74.94%	↑	★★★★★
Combination 10	41.36%	44.04%	45.50%	↑	★★★★
Immunizations for Adolescents					
Combination 1	84.18%	85.64%	84.43%	↑	★★★
Combination 2	28.71%	34.06%	34.31%	↑	★★
Lead Screening in Children					
Lead Screening in Children	77.62%	74.81%	74.93%	↓	★★★★
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%	66.01%	↑	★★★★
Well-Child Visits for Age 15 Months-30 Months—Two or More Well-Child Visits	60.51%	55.82%	70.70%	↑	★★★
Child and Adolescent Well-Care Visits					
Total	38.02%	42.20%	50.54%	↑	★★★
Medication Management					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	60.76%	60.38%	59.99%	↓	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	55.31%	58.98%	60.82%	↑	★★★
Effective Continuation Phase Treatment	40.78%	42.07%	42.60%	↑	★★

Measures	HEDIS 2020 (MY 2020) Rate	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Three-Year Trend	Star Rating
Appropriate Testing for Pharyngitis					
Total	80.22%	77.53%	80.05%	↓	★★★★★
Appropriate Treatment for Upper Respiratory Infection					
Total	86.54%	90.99%	89.90%	↑	★★
Asthma Medication Ratio					
Total	NA	68.37%	65.87%	—	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Total	51.14%	51.10%	59.55%	↑	★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	54.49%	42.28%	52.88%	↓	★★★★★
Continuation and Maintenance Phase	61.19%	50.11%	57.90%	↓	★★★★
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	67.78%	73.91%	75.14%	↑	★
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	42.43%	58.32%	69.01%	↑	★★
Bronchodilator	49.03%	67.19%	74.97%	↑	★
Statin Therapy for Patients With Cardiovascular Disease					
Statin Adherence 80%—Total	NA	67.32%	68.79%	—	★★
Statin Therapy for Patients With Diabetes					
Statin Adherence 80%—Total	NA	65.87%	67.79%	—	★★★
Use of Opioids at High Dosage*					
Use of Opioids at High Dosage	2.25%	1.72%	1.88%	↑	★★★★
Use of Opioids From Multiple Providers*					
Multiple Prescribers	15.87%	17.39%	17.07%	↓	★★★
Multiple Pharmacies	1.64%	1.63%	1.63%	↑	★★★
Multiple Prescribers and Multiple Pharmacies	1.22%	1.20%	1.16%	↑	★★★

* For this indicator, a lower rate indicates better performance.
—This symbol indicates that NCQA recommended a break in trending; therefore, the rate is not displayed.
"NC" indicates that NCQA recommended a break in trending; therefore, the rate could not be compared to the national Medicaid MY 2021 benchmarks.
"NA" indicates that the denominator was too small to calculate a rate (n<30); therefore, a rate is not displayed.
↓ Indicates performance worsened over a three-year time period.
↑ Indicates performance improved over a three-year time period.
HEDIS MY 2022 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★= At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Iowa Total Care demonstrated multiple levels of validation and quality analysis to ensure timely and accurate claims processing and adherence to State and federal regulations. Further, **Iowa Total Care** used a monthly encounter lag report to track claims from adjudication through encounter readiness and HHS submission. [**Quality** and **Timeliness**]

Strength #2: Iowa Total Care's performance in the Keeping Kids Healthy domain improved in CY 2023 in several areas. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator improved by more than 14 percentage points and finished at or above the 75th percentile, and the *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* indicator improved by nearly 15 percentage points. The *Child and Adolescent Well-Care Visits* measure improved by more than 8 percentage points. Further, the *Childhood Immunization Status—Combination 3* indicator rate increased to finish at or above the 90th percentile. [**Quality** and **Access**]

Strength #3: Iowa Total Care's performance in the Behavioral Health domain remained strong for the *Follow-Up After ED Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness* measures. All measure indicators demonstrated rate increases, with the *Follow-Up After ED Visit for Mental Illness* measure indicators both finishing at or above the 90th percentile and the *Follow-Up After Hospitalization for Mental Illness* measure indicators both finishing at or above the 75th percentile. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: Iowa Total Care's performance in the Women's Health domain remained low, as the *Chlamydia Screening in Women—Total* measure ranked below the 25th percentile. Continually low rates indicate that a large percentage of women were not being seen or screened by their providers for chlamydia. Chlamydia is one of the most frequently reported bacterial sexually transmitted infections in the United States. Early detection of chlamydia can help reduce or eliminate adverse health problems associated with untreated conditions. [**Quality**]

Why the weakness exists: The low rate for *Chlamydia Screening in Women—Total* suggest that barriers exist in access, provision of services, or understanding of the importance of timely screening for this conditions.

Recommendation: HSAG recommends that **Iowa Total Care** partner with primary care and obstetrics/gynecology (OB/GYN) providers to determine why some females were not screened for chlamydia. **Iowa Total Care** should also evaluate access to primary care and OB/GYN services in its network for females who were noncompliant for the measure. Further, HSAG also recommends that **Iowa Total Care** conduct an analysis to evaluate whether particular age groups or racial/ethnic groups have a significantly different rate for accessing chlamydia screenings. Upon identification of a root cause, **Iowa Total Care** should implement appropriate interventions (member education, transportation assistance, member rewards program, 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—Total*. These low rates indicate that patients receiving behavioral health treatment and using antipsychotic medication were not always being monitored properly. Addressing the physical health needs of members diagnosed with mental health conditions is an important way to improve overall health, quality of life, and economic outcomes. Additionally, monitoring of blood glucose and cholesterol testing are important components of ensuring appropriate management of children and adolescents on antipsychotic medications. [**Quality, Timeliness,** and **Access**]

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 inadequate follow-through on member testing. **Iowa Total Care** also noted gaps in provider awareness of required laboratory monitoring pertaining to medications and diagnoses as well as gaps in provider coding for claims submission.

Recommendation: HSAG recommends that **Iowa Total Care** conduct an analysis of member and provider data to identify ongoing trends in noncompliance after integration of behavioral health initiatives, reviewing data for elements such as geographic location, age groups or racial and ethnic groups, and provider-associated noncompliance. Upon identification of the root cause for ongoing noncompliance, **Iowa Total Care** should implement appropriate interventions (member education campaigns, transportation assistance, member rewards program, provider education, care coordination, etc.) to improve low performance rates within the Behavioral Health domain.

Compliance Review

Performance Results

Table 3-28 presents an overview of the results of the CY 2021 and CY 2022 compliance reviews for **Iowa Total Care**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements (i.e., requirements) it reviewed. If a requirement was not applicable to **Iowa Total Care** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

Table 3-28—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements M	NM	NA	Total Compliance Score
Standard I—Disenrollment: Requirements and Limitations	7	7	5	2	0	**71%**
Standard II—Member Rights and Member Information	20	20	18	2	0	**90%**
Standard III—Emergency and Poststabilization Services	10	10	10	0	0	**100%**
Standard IV—Availability of Services	9	9	8	1	0	**89%**
Standard V—Assurances of Adequate Capacity and Services	5	5	5	0	0	**100%**
Standard VI—Coordination and Continuity of Care	10	10	10	0	0	**100%**
Standard VII—Coverage and Authorization of Services	10	10	8	2	0	**80%**
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 XIII—Health Information Systems[1]	9	9	9	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	30	30	29	1	0	**97%**
Total	**193**	**193**	**179**	**14**	**0**	**93%**

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

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

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

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

[1] This standard includes a comprehensive assessment of the MCO's IS capabilities.

Based on the findings of the CY 2021 and CY 2022 compliance review activities, **Iowa Total Care** was required to develop and submit a CAP for each element assigned a score of *Not Met*. HHS and HSAG reviewed the CAP for sufficiency, and **Iowa Total Care** was responsible for implementing each action plan in a timely manner. Table 3-29 presents an overview of the results of the CY 2023 compliance review for **Iowa Total Care**, which consisted of a comprehensive review of the MCO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-29—Summary of CAP Implementation

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Disenrollment: Requirements and Limitations	2	2	**0**
Standard II—Member Rights and Member Information	2	2	**0**
Standard IV—Availability of Services	1	1	**0**
Standard VII—Coverage and Authorization of Services	2	1	**1**
Standard VIII—Provider Selection	2	2	**0**
Standard X—Grievance and Appeal Systems	4	4	**0**
Standard XIV—Quality Assessment and Performance Improvement Program	1	1	**0**
Total	**14**	**13**	**1**

Total CAP Elements: The total number of elements within each standard that required a CAP during the CY 2021 and CY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

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 demonstrated that it successfully remediated 13 of 14 elements, indicating the necessary policies, procedures, and initiatives were implemented and demonstrated compliance with the requirements under review. Further, **Iowa Total Care** remediated all elements for six of the seven standards reviewed: Disenrollment: Requirements and Limitations, Member Rights and Member Information, Availability of Services, Provider Selection, Grievance and Appeal Systems, and Quality Assessment and Performance Improvement Program. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: **Iowa Total Care** did not remediate one of the two CAP elements for the Coverage and Authorization standard, indicating continued gaps in the MCO's processes for issuing an ABD for payment denials. [**Quality** and **Timeliness**]

Why the weakness exists: Although **Iowa Total Care** demonstrated that efforts have been made to develop a list of claim denial codes that would trigger an ABD, the list of codes had not been finalized, and the process to send an ABD based on these codes had not been implemented. Additionally, the MCO confirmed that the Iowa Medicaid MCOs were working collectively to determine the most appropriate ABD notice template to use consistently across the Medicaid program. Of note, the ABD template that the MCO submitted was appropriate and met the intent of the federal rule; however, the MCO indicated that implementation of the denial of payment ABD process would not occur until 90 days following the collective decision on the type of communication that will be sent to members.

Recommendation: HSAG recommends that **Iowa Total Care** proceed with its existing plans of action to implement the ABD for denial of payment process to comply with federal rule.

Network Adequacy Validation

Performance Results

Table 3-30 presents the percentage of behavioral health providers with new pediatric behavioral health visits in 2022 for **Iowa Total Care**, across the Medicaid and Hawki programs, and in total. Please note that the Medicaid and Hawki programs utilize the same networks of contracted providers.

Table 3-30—Percentage of Behavioral Health Providers With Pediatric New Member Visits in 2022

		Medicaid	Hawki	Total
MCO and Provider Type	Total Number of Providers	Number (Percent) of Providers With New Member Visits	Number (Percent) of Providers With New Member Visits	Number (Percent) of Providers With New Member Visits
All Providers	2,556	571 (22.3%)	203 (7.9%)	609 (23.8%)
Inpatient Providers	27	8 (29.6%)	1 (3.7%)	8 (29.6%)
Outpatient Providers	2,529	563 (22.3%)	202 (8.0%)	601 (23.8%)

Note: Pediatric members are ages 18 years and under with continuous enrollment in Medicaid and/or Hawki in 2021 and 2022. Behavioral health visits are defined as visits with a behavioral health provider. A new member visit is defined as a visit with any behavioral health provider in 2022 for members who had no behavioral health visits in 2021. **Iowa Total Care** has the same provider network for Medicaid and Hawki. For this reason, the total number of providers is the same for Medicaid, Hawki, and overall. The total number of providers with new visits across lines of business (LOBs) may be smaller than the sum of Medicaid providers with new visits and Hawki providers with new visits because each provider may have new member visits in both LOBs, and these providers should not be double counted.

Table 3-31 presents the average number of pediatric new member visits in 2022 for all behavioral health providers, inpatient providers only, and outpatient providers only in the **Iowa Total Care** provider networks. The table is limited to providers with at least one new member visit.

Table 3-31—Average Number of Pediatric New Member Visits for Behavioral Health Providers in 2022

MCO, Provider Category, and LOB	Number of Providers With New Member Visits	Number of New Member Visits	Average Number of New Member Visits	Median Number of New Member Visits	Number of New Member Visits, 25th and 75th Percentiles
All Providers					
Hawki	203	290	1.4	1.0	1.0–2.0
Medicaid	571	2,694	4.7	2.0	1.0–5.0
Total	609	2,984	4.9	3.0	1.0–5.0
Inpatient Providers					
Hawki	1	1	1.0	1.0	1.0–1.0
Medicaid	8	56	7.0	3.0	1.0–8.0
Total	8	57	7.1	3.0	1.0–8.0
Outpatient Providers					
Hawki	202	289	1.4	1.0	1.0–2.0
Medicaid	563	2,638	4.7	2.0	1.0–5.0
Total	601	2,927	4.9	3.0	1.0–5.0

Note: Pediatric members are ages 18 years and under with continuous enrollment in Medicaid and/or Hawki in 2021 and 2022. Behavioral health visits are defined as visits with a behavioral health provider. A new member visit is defined as a visit with any behavioral health provider in 2022 for members who had no behavioral health visits in 2021. **Iowa Total Care** has the same provider network for Medicaid and Hawki. For this reason, the total number of providers is the same for Medicaid, Hawki, and overall. The total number of providers with new visits across LOBs may be smaller than the sum of Medicaid providers with new visits and Hawki providers with new visits because each provider may have new member visits in both LOBs, and these providers should not be double counted. The average, median, and percentile statistics were calculated for providers with at least one new member visit in 2022 only.

Table 3-32 and Table 3-33 present the demographic and geographic characteristics of **Iowa Total Care** pediatric members with behavioral health visits in 2021 and 2022, for Medicaid and Hawki, respectively.

Table 3-32—Demographic and Geographic Characteristics of ITC Medicaid Pediatric Members With Behavioral Health Visits in 2021 and 2022

Characteristic	Number (Percent) With New Visits in 2022	Number (Percent) With Visits in 2021 Only	Number (Percent) With Visits in Both Years	Number (Percent) With No Visits in Either Year
Age				
5 Years and Under	221 (0.8%)	79 (0.3%)	71 (0.3%)	27,265 (98.7%)
6 to 12 Years	1,173 (2.8%)	839 (2.0%)	1,175 (2.8%)	38,663 (92.4%)
13 to 18 Years	1,280 (3.9%)	1,380 (4.2%)	1,513 (4.6%)	28,985 (87.4%)

Characteristic	Number (Percent) With New Visits in 2022	Number (Percent) With Visits in 2021 Only	Number (Percent) With Visits in Both Years	Number (Percent) With No Visits in Either Year
Race/Ethnicity				
Hispanic*	278 (2.0%)	241 (1.7%)	239 (1.7%)	13,204 (94.6%)
White	1,307 (3.6%)	1,187 (3.2%)	1,511 (4.1%)	32,756 (89.1%)
Black or African American	174 (2.2%)	124 (1.5%)	154 (1.9%)	7,589 (94.4%)
American Indian or Alaska Native	16 (3.4%)	16 (3.4%)	30 (6.4%)	406 (86.8%)
Asian	14 (0.8%)	12 (0.7%)	9 (0.5%)	1,664 (97.9%)
Native Hawaiian and Other Pacific Islander	13 (1.7%)	12 (1.6%)	15 (2.0%)	709 (94.7%)
Two or More Races	117 (3.7%)	117 (3.7%)	113 (3.6%)	2,775 (88.9%)
Unknown	755 (2.0%)	589 (1.6%)	688 (1.8%)	35,810 (94.6%)
Sex				
Female	1,436 (2.9%)	1,179 (2.4%)	1,452 (2.9%)	46,006 (91.9%)
Male	1,238 (2.4%)	1,119 (2.1%)	1,307 (2.5%)	48,907 (93.0%)
Urbanicity**				
Rural	999 (2.4%)	840 (2.0%)	926 (2.3%)	38,303 (93.3%)
Urban	1,675 (2.7%)	1,458 (2.4%)	1,833 (3.0%)	56,610 (91.9%)

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

** Members with a residential address in a county defined as a Metropolitan Statistical Area are living in an urban area; all other members live in rural areas.

Note: Pediatric members are ages 18 years and under with continuous enrollment in Medicaid and/or Hawki in 2021 and 2022. Behavioral health visits are defined as visits with a behavioral health provider. A new visit is defined as a visit with any behavioral health provider in 2022 for members who had no behavioral health visits in 2021.

Table 3-33—Demographic and Geographic Characteristics of ITC Hawki Pediatric Members With Behavioral Health Visits in 2021 and 2022

Characteristic	Number (Percent) With New Visits in 2022	Number (Percent) With Visits in 2021 Only	Number (Percent) With Visits in Both Years	Number (Percent) With No Visits in Either Year
Age				
5 Years and Under	10 (0.7%)	7 (0.5%)	2 (0.1%)	1,366 (98.6%)
6 to 12 Years	102 (1.9%)	83 (1.6%)	109 (2.1%)	4,944 (94.4%)
13 to 18 Years	176 (3.3%)	179 (3.4%)	220 (4.2%)	4,715 (89.1%)

Characteristic	Number (Percent) With New Visits in 2022	Number (Percent) With Visits in 2021 Only	Number (Percent) With Visits in Both Years	Number (Percent) With No Visits in Either Year
Race/Ethnicity				
Hispanic*	13 (1.5%)	14 (1.6%)	13 (1.5%)	839 (95.4%)
White	171 (2.9%)	157 (2.7%)	196 (3.3%)	5,387 (91.1%)
Black or African American	6 (1.8%)	5 (1.5%)	3 (0.9%)	319 (95.8%)
American Indian or Alaska Native	1 (1.9%)	1 (1.9%)	1 (1.9%)	50 (94.3%)
Asian	2 (1.0%)	1 (0.5%)	2 (1.0%)	200 (97.6%)
Native Hawaiian and Other Pacific Islander	8 (2.5%)	5 (1.6%)	13 (4.1%)	294 (91.9%)
Two or More Races	6 (3.0%)	7 (3.5%)	8 (4.0%)	181 (89.6%)
Unknown	81 (2.0%)	79 (2.0%)	95 (2.4%)	3,755 (93.6%)
Sex				
Female	156 (2.7%)	135 (2.3%)	185 (3.2%)	5,360 (91.8%)
Male	132 (2.2%)	134 (2.2%)	146 (2.4%)	5,665 (93.2%)
Urbanicity**				
Rural	108 (1.9%)	107 (1.9%)	114 (2.0%)	5,266 (94.1%)
Urban	180 (2.8%)	162 (2.6%)	217 (3.4%)	5,759 (91.2%)

* Members identified as Hispanic can be of any race or combination of races. All other categories excluding Unknown are non-Hispanic.
** Members with a residential address in a county defined as a Metropolitan Statistical Area are living in an urban area; all other members live in rural areas.
Note: Pediatric members are ages 18 years and under with continuous enrollment in Medicaid and/or Hawki in 2021 and 2022. Behavioral health visits are defined as visits with a behavioral health provider. A new visit is defined as a visit with any behavioral health provider in 2022 for members who had no behavioral health visits in 2021.

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: More than 23 percent of **Iowa Total Care** behavioral health providers had a visit with at least one new member in CY 2022, indicating that some members looking for new behavioral health services were able to obtain services.

Weaknesses and Recommendations

Weakness #1: Approximately 76 percent of **Iowa Total Care** behavioral health providers did not have a visit with at least one new member in CY 2022.

Why the weakness exists: This could be due to either a lack of provider willingness to accept new behavioral health pediatric patients or a limited number of new pediatric patients requiring these services.

Recommendation: HSAG recommends combining the findings from this analysis with member experience reports to determine if there may be an access issue for pediatric patients seeking new behavioral health services. The results of this analysis, along with member experience and grievance information, can help **Iowa Total Care** assess whether this represents adequate access or a potential network adequacy concern for pediatric members seeking behavioral health services.

Encounter Data Validation

Performance Results—Targeted Comparative Analysis

Table 3-34 displays the percentage of records present in the files submitted by **Iowa Total Care** 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 **Iowa Total Care** (record surplus) by encounter type (i.e., institutional, and professional). **Lower rates indicate better performance for both record omission and record surplus**.

Table 3-34—Record Omission and Surplus, by Encounter Type

Encounter Data Type	Record Omission	Record Surplus
Professional	6.7%	5.0%
Institutional	5.2%	<0.1%

Table 3-35 and Table 3-36 display the results for key data elements related to professional and institutional encounter types, respectively. These tables include information on element omission, element surplus, element missing values, and element accuracy. **For the element omission and surplus indicators, lower rates indicate better performance. For the element accuracy indicator, higher rates indicate better performance.** However, for the element missing values indicator, lower or higher rates do not indicate better or worse performance.

Table 3-35—Data Element Omission, Surplus, Missing Values, and Accuracy: Professional Encounters

Key Data Element	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
Member ID	0.0%	0.0%	0.0%	100.0%

Key Data Element	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
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%	<0.1%	0.0%	99.8%
Billing Provider ZIP Code	0.3%	0.1%	<0.1%	68.6%
Billing Provider Taxonomy Code	<0.1%	<0.1%	26.3%	99.9%
Rendering Provider NPI	0.0%	40.4%	0.0%	>99.9%
Referring Provider NPI	1.6%	0.0%	55.5%	>99.9%
Primary Diagnosis Code	0.0%	0.0%	0.0%	100.0%
Procedure Code[5] (CDT, CPT, HCPCS)	0.0%	<0.1%	0.0%	>99.9%
Procedure Code Modifier[6]	<0.1%	<0.1%	56.2%	>99.9%
Units of Service	0.0%	0.0%	0.0%	99.7%

[1] Element Omission displays the percentage of records with values present in the **Iowa Total Care**'s submitted files but not in HHS' submitted files.

[2] Element Surplus displays the percentage of records with values present in HHS' submitted files but not in the **Iowa Total Care**'s submitted files.

[3] Element Missing Values displays the percentage of records with values missing from both HHS' submitted files and **Iowa Total Care**'s submitted files.

[4] Element Accuracy displays the percentage of records with the values present and having identical values in both **Iowa Total Care**'s submitted files and HHS' submitted files.

[5] Current Dental Terminology [CDT], Current Procedural Terminology [CPT], or Healthcare Common Procedure Coding System [HCPCS] code.

[6] Only the first procedure code modifier was assessed for the comparative analysis.

Table 3-36—Data Element Omission, Surplus, Missing Values, and Accuracy: Institutional Encounters

Key Data Element	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
Member ID	0.0%	0.0%	0.0%	100.0%
Header Service From Date	0.0%	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	0.0%	>99.9%
Billing Provider NPI	0.0%	<0.1%	0.0%	>99.9%
Billing Provider ZIP Code	0.3%	<0.1%	<0.1%	95.1%
Billing Provider Taxonomy Code	2.2%	<0.1%	<0.1%	90.2%
Attending Provider NPI	0.0%	0.0%	0.4%	100.0%
Referring Provider NPI	0.1%	<0.1%	96.3%	100.0%
Primary Diagnosis Code	0.0%	0.0%	0.0%	100.0%

Key Data Element	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
Procedure Code[5] (CDT, CPT, HCPCS)	0.1%	0.2%	15.7%	97.2%
Procedure Code Modifier[6]	0.4%	0.5%	75.6%	99.5%
Units of Service	0.0%	0.0%	0.0%	95.4%
Surgical Procedure Codes[7]	<0.1%	0.0%	94.5%	84.2%

[1] Element Omission displays the percentage of records with values present in the **Iowa Total Care**'s submitted files but not in HHS' submitted files.

[2] Element Surplus displays the percentage of records with values present in HHS' submitted files but not in the **Iowa Total Care**'s submitted files.

[3] Element Missing Values displays the percentage of records with values missing from both HHS' submitted files and **Iowa Total Care**'s submitted files.

[4] Element Accuracy displays the percentage of records with the values present and having identical values in both **Iowa Total Care**'s submitted files and HHS' submitted files.

[5] Current Dental Terminology [CDT], Current Procedural Terminology [CPT], or Healthcare Common Procedure Coding System [HCPCS] code.

[6] Only the first procedure code modifier was assessed for the comparative analysis.

[7] All submitted surgical procedure codes were ordered and concatenated as a single data element for the comparative analysis.

Table 3-37 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing or non-missing) for all key data elements relevant to each encounter data type.

Table 3-37—All Element Accuracy, by Encounter Type

Encounter Data Type	All Element Accuracy
Professional	29.0%
Institutional	26.2%

Note: The denominator for the all-element accuracy rate is defined differently from the denominators for the individual element accuracy rates since it includes data elements even if values are missing in both sources. If any of the data elements are an element omission, element surplus, or an inaccurate value match, the record will not be a positive hit for the all-element accuracy numerator.

Table 3-38 displays the percentage of legacy provider numbers in HHS' data that were not populated for professional and institutional encounters.

Table 3-38—Legacy Billing Provider Numbers Not Populated, by Encounter Type

Encounter Data Type	Legacy Billing Provider Numbers Not Populated
Professional	0.3%
Institutional	0.3%

Table 3-39 displays the percentage of legacy billing provider numbers in HHS' data that were populated for professional and institutional encounters, but key provider information did not match between HHS' and the **Iowa Total Care**'s data sources. The rate was calculated only when the values were present in both data sources. If at least one of the values was missing in either data source, then they were not included in the denominator.

Table 3-39—Legacy Billing Provider Number Populated, by Encounter Type

Encounter Data Type	ZIP Codes Did Not Match	Taxonomy Did Not Match
Professional	31.4%	0.1%
Institutional	4.9%	9.8%

Table 3-40 illustrates the percentage of legacy billing provider numbers in HHS' data that were populated for professional encounters, with HSAG confirming the provider type by place of service (POS), CPT, or both. The process to verify whether the provider type (derived from the legacy billing provider number) aligns with the services rendered on the claims data involved the following steps:

- Using the legacy billing provider number populated in the HHS-submitted encounter data, HSAG extracted the associated provider type from the HHS-submitted provider data.
- HSAG evaluated the assignment of these provider types, considering data elements from the encounter data such as POS, CPT codes, type of bill (TOB), and revenue codes.
- Data elements were grouped, and a subjective verification was conducted to ensure alignment with the assigned provider type.

Table 3-40—Legacy Billing Provider Type Validation by POS and CPT: Professional Encounters

Provider Type Matched Services on Claim on POS Only	Provider Type Matched Services on Claim on CPT Only	Provider Type Matched Services on Claim on Both POS and CPT
98.6%	99.4%	98.2%

Table 3-41 illustrates the percentage of legacy billing provider numbers in HHS' data that were populated for institutional encounters, with HSAG confirming the provider type by TOB, revenue code, CPT, or all three. For matching based on all three fields, the numerator and denominator were calculated when all fields were populated with non-missing values. The process to verify whether the provider type aligns with the services rendered on the claims data is the same process as described above for the professional encounter types.

Table 3-41—Legacy Billing Provider Type Validation by TOB, Revenue Code, and CPT: Institutional Encounters

Provider Type Matched Services on Claim on TOB Only	Provider Type Matched Services on Claim on Revenue Code Only	Provider Type Matched Services on Claim on CPT Only	Provider Type Matched Services on Claim on TOB, Revenue Code, and CPT
98.2%	>99.9%	99.8%	97.8%

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: A high level of element completeness (i.e., low element omission and surplus rates) was exhibited among encounters that could be matched between data extracted from HHS' data warehouse and data extracted from **Iowa Total Care**'s data system. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The record omission and surplus rates for professional encounters were 5.0 percent or greater. [**Quality**]

Why the weakness exists: The TCN and ICN values in **Iowa Total Care**'s transportation data file were switched. Thus, the records that could have been matched remained unmatched in the HHS-submitted data, contributing to the high record omission and surplus rates for professional encounters.

Recommendation: HSAG recommends that **Iowa Total Care** align its data submission practices, adhering closely to the specified data requirements and ensuring a more seamless integration into the analytical process. This adjustment will facilitate accurate and efficient data handling during subsequent phases of analysis and evaluation.

Weakness #2: The record omission rate for institutional encounters was greater than 5.0 percent. [**Quality**]

Why the weakness exists: Among all omitted records, more than 60.0 percent of these records had a Claim Frequency Code value of "8," indicating they were voided. Of note, out of all voided encounter records submitted by **Iowa Total Care**, more than 75.0 percent of these records were found in the HHS-submitted data.

Recommendation: HSAG recommends that **Iowa Total Care** actively address and resolve this issue, ensuring all data are submitted accurately and completely.

Weakness #3: Iowa Total Care had low accuracy rates for *Billing Provider ZIP Code* for professional encounters and for Billing Provider ZIP Code and *Billing Provider Taxonomy Code* for institutional encounters. [**Quality**]

Why the weakness exists: Iowa Total Care sourced the billing provider address and taxonomy codes from a different data source than HHS.

Recommendation: HSAG recommends that **Iowa Total Care** work with HHS to ensure that provider data are sourced from the same or a similar platform.

Weakness #4: Iowa Total Care had a lower *Surgical Procedure Codes* accuracy rate for institutional encounters. [**Quality**]

Why the weakness exists: **Iowa Total Care** included only five *Surgical Procedure Codes*, with repeated duplicate codes.

Recommendation: HSAG recommends that **Iowa Total Care** implement standardized quality controls to ensure accurate data extraction from its encounter data system.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-42 presents **Iowa Total Care**'s 2023 adult Medicaid and general child Medicaid CAHPS top-box scores.[3-7]Arrows (↓ or ↑) indicate 2023 scores that were statistically significantly higher or lower than the 2022 national average.

Table 3-42—Summary of 2023 CAHPS Top-Box Scores for ITC

	2023 Adult Medicaid	2023 General Child Medicaid
Composite Measures		
Getting Needed Care	86.5% ↑	87.4%
Getting Care Quickly	85.0% ↑	89.4%
How Well Doctors Communicate	93.7%	95.8%
Customer Service	90.4%	87.2%
Global Ratings		
Rating of All Health Care	57.4%	66.4%
Rating of Personal Doctor	72.0%	77.0%
Rating of Specialist Seen Most Often	61.9%	64.9%
Rating of Health Plan	62.7%	67.7% ↓
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	68.2%	▨
Discussing Cessation Medications	45.1%	▨
Discussing Cessation Strategies	40.8%	▨

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

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

↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.

↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.

▨ Indicates that the measure does not apply to the population.

[3-7] **Iowa Total Care** 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.

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 care quickly, as scores for the *Getting Needed Care* and *Getting Care Quickly* measures were statistically significantly higher than the 2022 NCQA adult Medicaid national averages. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Parents/caretakers of child members in the general child population had less positive overall experiences with their child's health plan, as the score for the *Rating of Health Plan* measure was statistically significantly lower than the 2022 NCQA child Medicaid national average. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate that parents/caretakers of child members in the general child population did not rate the care received from their child's health plan highly.

Recommendation: HSAG recommends that **Iowa Total Care** conduct root cause analyses or focus studies to determine why parents/caretakers of child members in the general child population are potentially perceiving a lack of overall quality of care from their child's health plan. Once a root cause or probable reasons for lower ratings are identified, **Iowa Total Care** can determine appropriate interventions, education, and actions to improve performance.

Scorecard

The 2023 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—MCO Comparative Information to review the 2023 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 MCO Quality Strategy goals and objectives. Table 3-43 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Iowa Total Care**'s Medicaid and Hawki members.

Table 3-43—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Behavioral Health	**Quality**, **Timeliness**, and **Access**—**Iowa Total Care** demonstrated strengths for managing behavioral health transitions of care through the PMV activity results. Specifically, **Iowa Total Care**'s HEDIS measure rates for the *Follow-Up After ED Visit for Mental Illness* measure were at or above the 90th percentile, and rates for the *Follow-Up After Hospitalization for Mental Illness* measure were at or above the 75th percentile but below the 90th percentile, indicating that **Iowa Total Care** implemented policies, procedures, and care coordination processes to ensure members received appropriate follow-up services after an ED visit or hospitalization for mental illness. **Iowa Total Care** should continue efforts to *Promote behavioral health by measuring follow-up after hospitalization/follow-up after emergency department visit (FUH/FUM) for pediatric and adult populations* in support of HHS' behavioral health goal outlined in the MCO Quality Strategy. However, the *Diabetes Monitoring for People With Diabetes and Schizophrenia*, *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, 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 that there are opportunities for improvement, as these rates fell below the 50th percentile. The *Diabetes Monitoring for People With Diabetes and Schizophrenia* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures were the lowest performing, as these rates fell below the 25th percentile for the second consecutive year. **Iowa Total Care** reported that it identified various barriers, such as providers' lack of understanding of the HEDIS measures and metrics, issues with provider coding completeness and/or accuracy, and lack of awareness of required laboratory monitoring for certain medications and diagnoses. While **Iowa Total Care** implemented several interventions, including provider education specific to HEDIS measures, a behavioral health provider pay-for-performance incentive program, a behavioral health case management program, offering in-home diabetic kits to targeted noncompliant members, and informing providers that home test kits were available to members, **Iowa Total Care** should evaluate the effectiveness of these interventions and determine if the interventions need to be continued, revised, or discontinued. Further, utilization data were obtained through the NAV activity, which focused on an analysis of behavioral health providers who saw new pediatric patients during CY 2022. The results indicate that 23.8 percent of **Iowa Total Care**'s behavioral health providers had a visit with at least one new pediatric patient in CY 2022, indicating that some pediatric members

Performance Area	Overall Performance Impact
	looking for new behavioral health services were able to access services. Conversely, 76.2 percent of **Iowa Total Care**'s behavioral health providers did not have a visit with at least one new pediatric member in CY 2022. This could be a result of fewer new pediatric members requesting behavioral health services or that the behavioral health provider is not accepting new behavioral health pediatric patients. Of importance, these utilization metrics are not indicative of better or worse performance, and further analysis would be needed to determine if potential access issues exist. **Iowa Total Care** should review the results of the NAV activity, conduct ongoing internal reviews of behavioral health utilization, and monitor for any barriers that may impede a new pediatric member from receiving behavioral health services.
Access to Care	**Quality**, **Timeliness**, and **Access**—Through HEDIS reporting, **Iowa Total Care** demonstrated both positive and negative results related to the MCO's impact on HHS' MCO Quality Strategy Access to Care goals to *Improve timeliness of postpartum care* and *Increase access to primary care and specialty care* in the areas of Women's Health, Preventive Care, and Care for Chronic Conditions. • Women's Heath—The Women's Health domain measure rates indicate that female members were not always receiving recommended health screenings, as the *Chlamydia Screening in Women* measure rate was below the 25th percentile, and rates for *Breast Cancer Screening* and *Cervical Cancer Screening* were at or above the 25th percentile but below the 50th percentile. **Iowa Total Care**'s *Timeliness of Postpartum Care* PIP, for the Remeasurement 2 measurement period, indicated that 77.9 percent of women who delivered a live birth had a timely postpartum care visit, which was an increase of 5.4 percentage points from the baseline. **Iowa Total Care** demonstrated that the PIP performance indicator achieved the goal of programmatically significant improvement over the baseline rate through intervention efforts. While **Iowa Total Care** demonstrated programmatically significant improvement, the performance rate increase was not statistically significant. These results indicate that **Iowa Total Care** should continue to implement active, innovative improvement strategies that have the potential to directly impact the performance indicator outcomes; continue to evaluate each intervention to determine its effectiveness; and use the results from the evaluation process to continue, revise, or discontinue each intervention, as appropriate. • Preventive Care—For the Access to Preventive Care and Keeping Kids Healthy domains, **Iowa Total Care**'s rates demonstrated mixed performance. The three rates under the *Adults' Access to Preventive/Ambulatory Health Services* measure were at or above the 50th percentile but below the 75th percentile, and all three rates under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure ranked below the 25th

Performance Area	Overall Performance Impact
	percentile, indicating that barriers may exist for children and adolescents in receiving BMI assessments and/or counseling for nutrition and physical activity. As such, **Iowa Total Care** should conduct an analysis to determine existing barriers and implement interventions to address any identified barriers. **Iowa Total Care** demonstrated better performance in the Keeping Kids Healthy domain, as seven of the eight measures rated at or above the 50th percentile, with three of the seven measures having rates at or above the 75th percentile but below the 90th percentile, and one measure rate at or above the 90th percentile. *Immunizations for Adolescents—Combination 2* was the lowest-performing measure in the Keeping Kids Healthy domain, with a rate at or above the 25th percentile but below the 50th percentile. This lower-performing rate indicates that opportunities exist to improve performance for the administration of the combination 2 immunization to adolescents. Receiving recommended immunizations can improve health outcomes and lessen the potential for chronic health issues later in life. • Care for Chronic Conditions—Members appear to have been accessing timely services to obtain disease-specific care they needed, as indicated by HEDIS rates in the Living With Illness domain for the *Blood Pressure Control for Patients With Diabetes* and *Eye Exam for Patients With Diabetes* measures, which ranked at or above the 75th percentile but below the 90th percentile. However, four of the seven rates ranked at or below the 50th percentile, with two of those rates below the 25th percentile, indicating that many members were not receiving needed disease-specific care that could impact their overall health. Additionally, within the Medication Management domain, seven of the 18 measure rates ranked below the 50th percentile, with two of those measure rates below the 25th percentile. These results suggest that some members were not accessing care, or that providers were not effectively treating some members' conditions through appropriate medication management. However, two of the 18 rates ranked at or above the 75th percentile but below the 90th percentile, and two measures ranked at or above the 90th percentile, indicating that some members diagnosed with pharyngitis or ADHD received appropriate medication management for their condition, and that many members were not using opioids at a high dosage. **Iowa Total Care**'s adult Medicaid population reported positive experiences in *Getting Needed Care* and *Getting Care Quickly*, as these scores were statistically significantly higher than the 2022 NCQA Adult Medicaid national average, as reported through CAHPS. Additionally, while the scores for the general child Medicaid population were not statistically significantly higher than the prior year for *Getting Needed Care* and *Getting Care Quickly,* the child population had a slightly higher percentage of satisfaction reported than the adult Medicaid population.

Performance Area	Overall Performance Impact
Voice of the Customer	**Quality**—Through the 2023 CAHPS activity, **Iowa Total Care** achieved scores that were statistically significantly higher than the 2022 national average in *Getting Needed Care* and *Getting Care Quickly* for the adult Medicaid survey. **Iowa Total Care**'s members reported that it was easy to obtain care, tests, or treatment, and were able to obtain care for illness or injury, and nonurgent appointments as soon as needed. Additionally, for the general child Medicaid population, the scores for *Getting Needed Care* and *Getting Care Quickly* were 87.7 percent and 89.4 percent, respectively. However, the score for *Rating of Health Plan* for the general child Medicaid population had a statistically significantly lower score than the 2022 national average, which suggests that opportunities still exist for **Iowa Total Care** to conduct further analysis of the potential barriers that may contribute to parents/guardians of child members' dissatisfaction with the health plan. **Iowa Total Care**'s *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*, as demonstrated through the PIP results, declined from the baseline rate of 91 percent and Remeasurement 1 rate of 94.4 percent to 79.4 percent for Remeasurement 2. **Iowa Total Care** reported that a lack of internal methods to communicate and disseminate information related to member programs or updates, limited knowledge of CSRs regarding pharmacy benefits, and overuse of callbacks and transfers to get members needed information were barriers to member satisfaction in this area. Although **Iowa Total Care** implemented interventions to address the identified barriers, including but not limited to updates to internal communication methods, a guide developed to answer common pharmacy-related questions and a method for direct routing of questions to pharmacy team, and review of after-call surveys and quality checks of CSRs, these interventions do not appear to have positively impacted the barriers, as there was a statistically significant decline from the baseline measurement period. **Iowa Total Care** should continue to evaluate each intervention to determine effectiveness and use the evaluation process to determine if the intervention should be continued, revised, or discontinued, as appropriate.
Health Information Systems	**Quality**—Through the CY 2023 PMV activity, **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 accurate encounter data to HHS. HSAG did not identify any concerns with **Iowa Total Care**'s processes. **Iowa Total Care** demonstrated multiple levels of validation and quality analysis to ensure timely and accurate claims processing and adherence to State and federal regulations. Further, **Iowa Total Care** used a monthly encounter lag report to track claims from adjudication through encounter readiness and HHS submission. Finally, through the EDV activity, the encounters submitted by **Iowa Total Care** were relatively complete and accurate.

Molina Healthcare of Iowa, Inc.

Validation of Performance Improvement Projects

Performance Results

Molina of Iowa was a new MCO in Iowa effective July 1, 2023; therefore, the MCO did not have sufficient data to conduct PIPs in CY 2023. **Molina of Iowa**'s PIP results will be included in the CY 2024 EQR technical report.

Performance Measure Validation

Molina of Iowa was a new MCO in Iowa effective July 1, 2023; therefore, an audit was not conducted since the MCO did not have any MY 2022 performance measure data for review. **Molina of Iowa**'s PMV results will be included in the CY 2024 EQR technical report.

Compliance Review

Molina of Iowa was a new MCO in Iowa effective July 1, 2023; therefore, the compliance review activity was not conducted. Instead, the MCO went through a comprehensive readiness review process in CY 2023 that included all federal compliance review standards. Results of the readiness review were provided to CMS, as required. **Molina of Iowa** will be included in the CY 2024 compliance review activity (which begins a new three-year compliance review cycle), which will be reported in the CY 2024 EQR technical report.

Network Adequacy Validation

Molina of Iowa was a new MCO in Iowa effective July 1, 2023; therefore, NAV was not conducted since the MCO did not have any MY 2021 and MY 2022 behavioral health utilization data for review in alignment with the CY 2023 scope for this activity. Of note, the MCO went through a comprehensive readiness review process in CY 2023 that included an assessment of **Molina of Iowa**'s network. Results of the readiness review, including information about **Molina of Iowa**'s network, were provided to CMS. Results from **Molina of Iowa**'s NAV activity, in compliance with CMS EQR *Protocol 4. Validation of Network Adequacy*, February 2023[3-8], will be included in the CY 2024 EQR technical report.

[3-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 29, 2024.

Encounter Data Validation

Performance Results—Information Systems Review

Representatives from **Molina of Iowa** completed an HHS-approved questionnaire supplied by HSAG. Upon review, HSAG identified follow-up questions based on **Molina of Iowa**'s initial questionnaire responses, and **Molina of Iowa** responded to these specific questions. To support its questionnaire responses, **Molina of Iowa** submitted a wide range of supporting documents in varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Molina of Iowa** regarding its encounter data processes.

Table 3-44 provides a list of the multifaceted analysis conducted for IS review. The table contains key findings based on HSAG's overall understanding of the encounter data processes and the IS infrastructure's abilities to produce complete and accurate encounter data.

Table 3-44—IS Review Results-Molina

Analysis	Key Findings
IS Review	
Encounter data sources and systems	• For professional, institutional, and National Council for Prescription Drug Programs (NCPDP) encounters, **Molina of Iowa** used QNXT and Edifecs as its primary software for claim adjudication and encounter preparation. • For pharmacy encounters, claims were processed and validated at point of sale (POS). With vision claims, validation was completed through Eye Manager and processing of claims was done by Biztalk. Non-emergency medical transportation (NEMT) files were validated and processed by Oracle Service-Oriented Architecture (SOA). • **Molina of Iowa** had processes in place to detect and identify duplicate claims and ensured appropriate logic was being used to identify denied claims/encounters. • **Molina of Iowa** and its subcontractors (e.g., CVS, March Vision, and Access2Care) collected and maintained provider data. **Molina of Iowa** collected and maintained member enrollment data.
Payment structures[1,2]	• **Molina of Iowa** submitted various services as encounters under bundled payment structures (e.g., global surgery, professional delivery services, end-stage renal disease [ESRD]). • Third party liability (TPL) data were collected, validated, and maintained through multiple sources, with 834 files serving as the primary source. **Molina of**

Analysis	Key Findings
	Iowa processed claims without TPL prior to submission, subsequently adjudicating claims to secondary payer upon TPL coverage receipt. • In cases where **Molina of Iowa** identified a primary TPL without a corresponding primary explanation of payment (EOP), the claim would be denied. • In general, **Molina of Iowa** indicated the possibility of scenarios that could lead to issuance of a zero-payment or zero-pay claims.
Encounter data quality monitoring[3]	• **Molina of Iowa** performed all quality checks on the encounter data stored in-house; however, it did not validate claim volume by submission month/per member per month (PMPM) or electronic data interchange (EDI) compliance edits. • **Molina of Iowa** performed claim volume and field-level completeness and validity checks on the three encounter types (i.e., NEMT, pharmacy, and vision) submitted to **Molina of Iowa** by the subcontractors. However, none of these encounters underwent checks for EDI compliance or timeliness. • **Molina of Iowa**'s subcontractors performed several data quality checks on the encounter data collected. These checks included but were not limited to analyzing claim volume by submission month (for vision); assessing field-level completeness and validity (for NEMT, pharmacy, and vision); evaluating timeliness (for vision); and ensuring alignment between payment fields in claims and financial reports (for pharmacy). • Additionally, **Molina of Iowa**'s subcontractors for pharmacy and vision performed checks for EDI NCPDP edits and EDI compliance edits, respectively.

[1] **Molina of Iowa** only began providing services in Iowa on July 1, 2023. Due to a limited amount of claims data in its systems, **Molina of Iowa** was unable to provide accurate payment methodology information for inpatient, outpatient, and pharmacy encounters.

[2] At the time of the survey, **Molina of Iowa** did not have any capitated providers.

[3] When the questionnaire was completed, **Molina of Iowa** had only been submitting data for one month, and no issues or challenges were identified regarding submitting encounter to HHS at that time.

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: Molina of Iowa demonstrated its capability to collect and process encounter data, and to transmit these data to HHS. **Molina of Iowa** has also established data review and correction processes that efficiently address quality concerns identified by HHS. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Molina of Iowa did not indicate that timeliness checks were performed for claims/encounters originating from the NEMT and pharmacy subcontractors. [**Quality** and **Timeliness**]

Why the weakness exists: This may be considered a weakness because timeliness quality checks are crucial to ensuring that claims and encounters are submitted within stipulated time frames.

Recommendation: Molina of Iowa should enhance its timeliness quality checks by considering, among other actions:

- Implementing regular timeliness audits.
- Adopting automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions.
- Periodically reviewing and adjusting timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Consumer Assessment of Healthcare Providers and Systems Analysis

Molina of Iowa did not start providing services until July 2023; therefore, CAHPS results were not available for CY 2023. **Molina of Iowa**'s CAHPS results will be included in the CY 2024 EQR technical report.

Scorecard

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

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

Molina of Iowa was a new MCO in Iowa effective July 1, 2023; therefore, HSAG did not have sufficient data to perform a comprehensive assessment of **Molina of Iowa**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services.

4. Assessment of Prepaid Ambulatory Health Plan Performance

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2023 review period to evaluate the performance of PAHPs on providing quality, timely, and accessible healthcare services to DWP and Hawki members. Quality, as it pertains to EQR, means the degree to which the PAHPs increased the likelihood of members' desired outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to HHS' network adequacy standards) and §438.206 (adherence to HHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the PAHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in CY 2023 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For the CY 2023 validation, the PAHPs continued the HHS-mandated PIP topic to address annual preventive dental visits, reporting Remeasurement 1 data for the performance indicators. HSAG conducted validation on the PIP Design (Steps 1 through 6, which included a review of each PAHP's selected PIP topic, aim statement, identified population, sampling method, performance indicator(s), and data collection procedures, as applicable), Implementation (Step 7—Review the Data Analysis and Interpretation of PIP Results and Step 8—Assess the Improvement Strategies), and Outcomes (Step 9—Assess the Likelihood that Significant and Sustained Improvement Occurred) stages of the selected PIP topic for each PAHP Table 4-1 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 the measures 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, 2022, through June 30, 2023.

Table 4-2—List of Performance Measures for PAHPs

2023 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
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
Providers Seeing Patients	Administrative	HHS

Compliance Review

HHS requires its contracted PAHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet mandatory EQR requirements. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The current three-year compliance review cycle was initiated in CY 2021 and comprised 14 program areas referred to as standards. At HHS's direction, HSAG conducted a review of the first seven federally required standards and requirements in Year One (CY 2021) and a review of the remaining federally required seven standards and requirements in Year Two (CY 2022) of the three-year compliance review cycle. This CY 2023 (Year Three) compliance review activity consisted of a re-review of the standards that were not fully compliant during the CY 2021 (Year One) and CY 2022 (Year Two) compliance review activities, as indicated by the elements (i.e., requirements) that received *Not Met* scores and required CAPs to remediate the noted deficiencies. Table 4-3 outlines the standards reviewed over the three-year compliance review cycle.

Table 4-3—Compliance Review Standards

Standard	Associated Federal Citation[1]		Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of each PAHP's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		

Standard	Associated Federal Citation[1]		Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
	Medicaid	CHIP			
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b)	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1110 §457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240(b)		✓	

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

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

Network Adequacy Validation

Secret Shopper Survey

During September and October 2023, HSAG completed a secret shopper telephone survey among dental providers' offices contracted with the PAHPs to serve Medicaid members enrolled in the DWP, DWP Kids, and Hawki programs. The primary purpose of the secret shopper survey was to collect dental cleaning appointment availability information for Medicaid patients new to the provider location.

A secret shopper is a person employed to pose as a patient to evaluate the validity of available provider information (e.g., accurate location information). The secret shopper telephone survey allows for objective data collection from healthcare providers while minimizing potential bias introduced by knowing the identity of the surveyor. Specific survey objectives included the following:

- Determine if the contact information (i.e., phone number and address) was accurate for the dental providers reported by the PAHPs as being contracted providers.
- Determine whether dental service locations accepted patients enrolled with the requested PAHP for the DWP Adults, DWP Kids, or Hawki programs and the degree to which PAHP and program acceptance aligned with the PAHPs' provider data.

- Determine whether dental service locations that accepted the program for the requested PAHP accepted new patients and the degree to which new patient acceptance aligned with the PAHPs' provider data.
- Determine appointment availability with the sampled dental service locations for preventive dental care.

Several limitations and analytic considerations must be noted when reviewing the results of the secret shopper telephone surveys. These limitations are located in Appendix A. External Quality Review Activity Methodologies.

Encounter Data Validation

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, HHS requires its contracted PAHPs to submit high-quality encounter data. HHS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. In CY 2023, HSAG conducted and completed the following core evaluation activity for the EDV study for the two PAHPs.

- **Comparative analysis**—analysis of HHS' electronic encounter data completeness and accuracy through a comparison between HHS' electronic encounter data and the data extracted from the PAHPs' data systems, along with technical assistance provided to PAHPs that perform poorly in the comparative analysis.

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, Implementation, and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 4-4 displays the overall validation rating and the baseline and Remeasurement 1 results for each performance indicator.

Table 4-4—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.	79.21%	79.05% ⇔	
		2. (Hawki) The percentage of members 18 years of age and younger [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	61.09%	61.94% ↑	
		3. (DWP Kids) The percentage of members 18 years of age and younger [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	49.88%	50.79% ↑	

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 PIP activities for CY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for CY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PAHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

For the 2023 validation, **Delta Dental** revised the baseline data provided in the prior year for the DWP adult performance indicator. During the prior measurement period, the PAHP incorrectly captured the eligible population as determined by HHS. The PAHP corrected the requirement that the eligible population must have had a dental visit during the measurement period and regenerated the performance indicator data.

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 4-5 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the PAHP to support achievement of the PIP goals and address the barriers.

Table 4-5—Remeasurement 1 Barriers and Interventions for DDIA

Barriers	Interventions
Members are calling into the member services helpline multiple times in a short period of time. This creates additional burden on member services staff and creates additional barriers to accessing care and information about member benefits.	Changed member service representative talking points, developed internal procedural changes, improved customer service notes, and developed a provider information resource log and a probing questions resource document.
Young adult DWP members may not understand their benefits, the importance of regular dental services, and effective oral hygiene. Additionally, these members are undergoing many transitions, including moving out of their guardian's homes and moving away to college, which means there is a lack of updated contact information (i.e., phone numbers and addresses) on file for them.	Dental Kits consist of members receiving a mailed kit, which included a toothbrush, toothpaste, dental floss, and information about their DWP benefits. Outbound calls consist of identified members receiving an outbound call from a live representative to educate them about their benefits, help them answer any questions and find a provider, and encourage members to update their contact information.
The 3- and 4-year-old DWP Kids and Hawki member populations may not be receiving fluoride services and/or education through official institutions (e.g., Head Start or school) if they are not enrolled. Additionally, many families may not be receiving these services or education because they are not regularly seeing a dentist.	Utilized targeted tele-dentistry through partnership with TeleDentistry.com for 3-year-old DWP Kids and Hawki member populations who had not received fluoride services or any preventive service within the last 12 months.

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

Strength #2: Delta Dental demonstrated statistically significant improvement over the baseline for the second and third performance indicators during the first remeasurement period. [**Quality**, **Access**, and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Delta Dental met 88 percent of the requirements within the Design stage of the project. The Design stage establishes the methodological framework for the PIP, and any gaps in the framework may impact the accuracy of the data reported. [**Quality**]

Why the weakness exists: Delta Dental had opportunities for improvement specific to its DWP Adult population and following the State-defined indicator specifications for describing the eligible population, as the appropriate codes were not included in the description.

Recommendation: HSAG recommends that **Delta Dental** describe and collect data for the eligible population as defined in the HHS specifications.

Performance Measure Validation

Performance Results

HSAG reviewed **Delta Dental**'s membership/eligibility data system, encounter data processing system, provider data 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, primary source verification (PSV) was completed. **Delta Dental** demonstrated an understanding of the measure specifications overall. HSAG did identify minor concerns with source code logic and measure specification adherence for one measure; however, **Delta Dental** was able to update their source code per the specification. HSAG determined that **Delta Dental**'s data integration and measure reporting processes were adequate and ensured data integrity and accuracy.

Table 4-6 displays measure designations and reportable measure rates for DWP Adults, Table 4-7 displays measure designations and reportable measure rates for DWP Kids, and Table 4-8 displays measure designations and reportable measure rates for the Hawki program. **Delta Dental** received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 4-6—2023 DDIA Performance Measure Designations and Rates for DWP Adults

Performance Measure		2021 Rate	2022 Rate	2023 Measure Designation	2023 Results		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	246,053	268,860	*R*	287,814	—	—
2	*Members Who Accessed Dental Care*	30.97%	29.09%	*R*	287,814	83,526	29.02%
3	*Members Who Received Preventive Dental Care*	75.49%	71.93%	*R*	83,526	62,821	75.21%
4	*Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation*	48,653	49,259	*R*	55,817	—	—
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*	26,657	29,405	*R*	—	33,850	—
6	*Members Who Received a Preventive Examination and a Follow-Up Examination*	54.79%	59.69%	*R*	55,817	33,850	60.64%

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

Table 4-7—2023 DDIA Performance Measure Designations and Rates for DWP Kids

Performance Measure		2022 Rate	2023 Measure Designation	2023 Results		
				Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	189,938	*R*	204,658	—	—
3	*Members Who Received Preventive Dental Care*	47.20%	*R*	204,658	104,678	51.15%
7	*Providers Seeing Patients*	**	*R*	900	762	84.67%

— A dash indicates a value is not applicable to the performance measure.
**The measure was not yet published in the MY.

Table 4-8—2023 DDIA Performance Measure Designations and Rates for Hawki Dental Plan

	Performance Measure	2022 Rate	2023 Measure Designation	2023 Results		
				Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	60,642	*R*	53,976	—	—
3	*Members Who Received Preventive Dental Care*	56.23%	*R*	53,976	33,039	61.21%

— 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 of measures and compared performance against its PIPs and Quality Assurance and Performance Improvement (QAPI) program to identify opportunities for improvement. **Delta Dental** monitored measure rates monthly and used the data for rate trending and for validation of source code accuracy. [**Quality**]

Strength #2: Delta Dental addressed HSAG's recommendation for reviewing manually adjusted claims to ensure accuracy of payment and coding in the adjustment process. **Delta Dental** reported conducting monthly quality analysis reviews on both manually processed and systematically processed claims, departmental quality assurance reviews for manually processed claims, and a regular review with operations leaders for claims processing oversight. [**Quality**]

Strength #3: Delta Dental's rates for the *Members Who Received Preventive Dental Care* measure increased by at least 3 percentage points for each dental program (i.e., DWP Adults, DWP Kids, and Hawki) in CY 2023, indicating that more members were accessing preventive dental care for avoidance of potentially preventable dental complications. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: During review of the Rate Reporting Template with member-level detail, HSAG observed source code restrictions applied to numerator compliance for the *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* measure. [**Quality**]

Why the weakness exists: **Delta Dental** noted that the measurement language appeared to restrict numerator compliant services to the fiscal year, which resulted in the error of limiting inclusion criteria and a significant decrease in the overall rate.

Recommendation: Although **Delta Dental** confirmed updates to its source code pertaining to the measure specifications, HSAG recommends that **Delta Dental** conduct additional review of the measurement specifications and conduct visual validation of the rate template using filters or formulas prior to HHS or HSAG submission to ensure all data are reported accurately against the technical specifications.

Weakness #2: **Delta Dental**'s rates for the *Members Who Accessed Dental Care* measure continued to gradually decline in 2022 and 2023. [**Access**]

Why the weakness exists: **Delta Dental**'s total number of *Members With at Least Six Months of Coverage* increased in 2022 and 2023; however, the rate of *Members Who Accessed Dental Care* decreased, which indicates that **Delta Dental**'s newer members were not accessing dental care proportionately within their first six months to one year of eligibility.

Recommendation: HSAG recommends that **Delta Dental** conduct a segmentation analysis of the noncompliant members to identify trends in demographics for the noncompliant population. HSAG also recommends that **Delta Dental** identify targeted interventions to increase knowledge and awareness of dental care benefits for members within their first year of eligibility.

Compliance Review

Performance Results

Table 4-9 presents an overview of the results of the CY 2021 and CY 2022 compliance reviews for **Delta Dental**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements (i.e., requirements) reviewed. If a requirement was not applicable to **Delta Dental** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

Table 4-9—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	6	6	6	0	0	**100%**
Standard II—Member Rights and Member Information	18	17	14	3	1	**82%**
Standard III—Emergency and Poststabilization Services	10	10	7	3	0	**70%**
Standard IV—Availability of Services	7	7	7	0	0	**100%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard V—Assurances of Adequate Capacity and Services	4	4	4	0	0	**100%**
Standard VI—Coordination and Continuity of Care	7	7	7	0	0	**100%**
Standard VII—Coverage and Authorization of Services	10	10	9	1	0	**90%**
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[1]	13	13	11	2	0	**85%**
Standard XIV—Quality Assessment and Performance Improvement Program	10	8	7	1	2	**88%**
Total	**155**	**150**	**128**	**22**	**5**	**85%**

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] This standard includes a comprehensive assessment of the PAHP's IS capabilities.

Based on the findings of the CY 2021 and CY 2022 compliance review activities, **Delta Dental** was required to develop and submit a CAP for each element assigned a score of *Not Met*. HHS and HSAG reviewed the CAP for sufficiency, and **Delta Dental** was responsible for implementing each action plan in a timely manner. Table 4-10 presents an overview of the results of the CY 2023 compliance review for **Delta Dental** which consisted of a comprehensive review of the PAHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 4-10—Summary of CAP Implementation

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard II—Member Rights and Member Information	3	1	**2**
Standard III—Emergency and Poststabilization Services	3	3	**0**

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard VII—Coverage and Authorization of Services	1	1	**0**
Standard VIII—Provider Selection	2	2	**0**
Standard IX—Confidentiality	1	1	**0**
Standard X—Grievance and Appeal Systems	6	6	**0**
Standard XI—Subcontractual Relationships and Delegation	2	2	**0**
Standard XII—Practice Guidelines	1	1	**0**
Standard XIII—Health Information Systems[1]	2	2	**0**
Standard XIV—Quality Assessment and Performance Improvement Program	1	1	**0**
Total	**22**	**20**	**2**

Total CAP Elements: The total number of elements within each standard that required a CAP during the CY 2021 and CY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1] This standard includes a comprehensive assessment of the PAHP'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: Delta Dental demonstrated that it successfully remediated 20 of 22 elements, indicating the necessary policies, procedures, and initiatives were implemented and demonstrated compliance with the requirements under review. Further, **Delta Dental** remediated all elements for nine of the 10 standards reviewed: Emergency and Poststabilization Services, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: **Delta Dental** did not remediate two of the three CAP elements for the Member Rights and Member Information standard, indicating continued gaps in the PAHP's processes to ensure that all critical member materials included appropriate taglines and that the provider directory included all required information. [**Quality** and **Access**]

Why the weakness exists: **Delta Dental**'s written member materials did not include taglines in a conspicuously visible font, and the PAHP's paper provider directory did not include taglines. Additionally, although **Delta Dental**'s online provider directory contained a search field for providers with offices that are handicap accessible, it did not specifically identify whether the providers' offices have accommodations for people with physical disabilities, including exam room(s) and equipment. The paper directory did not contain information related to providers' accessibility information, and the PAHP's professional application and credentialing forms only contained questions related to an office being handicap accessible, but did not contain specific information related to equipment.

Recommendation: HSAG required **Delta Dental** to submit an action plan to address the deficiencies and demonstrate that taglines in the prevalent non-English languages in Iowa are in a conspicuously visible font size and explain the availability of written translation or oral interpretation to understand the information provided, include information on how to request auxiliary aids and services, and include the toll-free and TTY/TDD telephone number of the PAHP's member/customer service unit as stipulated in 42 CFR §438.10. **Delta Dental** was also required to demonstrate that all critical member materials include taglines, develop a methodology and outreach plan to collect accessibility data from its network providers, and demonstrate significant progress in updating the provider directory with specific accessibility indicators. As such, HSAG recommends that **Delta Dental** continue to implement its action plans to assure full remediation of the deficiencies. HSAG also recommends that **Delta Dental** complete an annual review of its taglines for all critical member materials and the provider directory to ensure continued compliance.

Network Adequacy Validation

Performance Results

Through the secret shopper survey activity, HSAG attempted to contact 157 sampled provider locations (i.e., "cases") for **Delta Dental**, with an overall response rate of 87.3 percent (137 cases) among **Delta Dental**'s three programs. Table 4-11 summarizes the CY 2023 secret shopper survey response rates for **Delta Dental** and for each of **Delta Dental**'s programs.

Table 4-11—Summary of DDIA Secret Shopper Survey Results for Routine Dental Visits, by Program

Program	Response Rate		Offering Dental Services		Accepting PAHP		Accepting Iowa Medicaid	
	Cases Reached	Rate (%)[1]	Offering Dental Services	Rate (%)[2]	Accepting PAHP	Rate (%)[2]	Accepting Iowa Medicaid	Rate (%)[2]
DWP Adults	52	78.8%	48	92.3%	45	86.5%	40	76.9%
DWP Kids	21	100%	19	90.5%	13	61.9%	13	61.9%
Hawki	64	91.4%	63	98.4%	17	26.6%	14	21.9%
DDIA Total	**137**	**87.3%**	**130**	**94.9%**	**75**	**54.7%**	**67**	**48.9%**

[1] The denominator includes all sampled providers.
[2] The denominator includes cases reached.

Table 4-12 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **Delta Dental** and for each of **Delta Dental**'s enrolled programs. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 4-12—Summary of DDIA Secret Shopper Survey Appointment Availability Results, by Program

	Accepting New Patients		Cases Offered an Appointment		Appointment Wait Time (Calendar Days)
Program	Number	Rate(%)[1]	Number	Rate(%)[1]	Average
DWP Adults	35	67.3%	24	46.2%	47
DWP Kids	11	52.4%	5	23.8%	84
Hawki	9	14.1%	5	7.8%	69
DDIA Total	**55**	**40.1%**	**34**	**24.8%**	**55**

[1] The denominator includes cases reached.

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: Of the 157 total survey cases, 87.3 percent (n=137) of the provider locations could be contacted. **[Quality** and **Access]**

Strength #2: Of the cases reached, 94.9 percent of provider locations offered dental services. **[Access]**

Weaknesses and Recommendations

Weakness #1: Of the cases reached, 54.7 percent of provider locations accepted **Delta Dental**, 48.9 percent accepted Medicaid, and 40.1 percent accepted new patients. **[Access]**

Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **Delta Dental**'s data included inaccurate information regarding the provider location's acceptance of **Delta Dental**, Medicaid, and new patients.

Recommendation: HSAG recommends that **Delta Dental** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect Medicaid acceptance and new patient acceptance) to address the provider data deficiencies and educate providers' offices on the Medicaid program. Additionally, **Delta Dental** should adhere to any remediation requirements imposed by HHS.

Weakness #2: Among the cases reached, the overall appointment rate was 24.8 percent, with an overall average wait time of 55 calendar days for **Delta Dental**. **[Access]**

Why the weakness exists: For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included being required to complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid identification (ID) number. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Delta Dental** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Delta Dental** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Table 4-13 displays the percentage of records present in the files submitted by the **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).

Table 4-13—Record Omission and Surplus for DDIA

Record Omission	Record Surplus
1.7%	0.5%

Table 4-14 displays the element omission, element surplus, element missing values, and element accuracy indicator 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. For element accuracy, higher rates indicate better performance. However, for the element missing values indicator, lower or higher rates do not indicate better or worse performance.

Table 4-14—Element Omission, Surplus, Missing Values, and Accuracy: DDIA

Key Data Elements	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
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%	99.9%
Detail Service To Date	0.0%	0.0%	0.0%	99.9%
Billing Provider National Provider Identifier (NPI)	0.0%	0.0%	0.0%	95.0%
Rendering Provider NPI	0.0%	0.0%	0.0%	95.4%
Current Dental Terminology (CDT) Code	0.0%	0.0%	0.0%	99.3%
Units of Service	0.0%	0.0%	0.0%	96.5%
Tooth Number	<0.1%	<0.1%	76.1%	99.6%
Tooth Surface 1-5[5]	9.2%	0.0%	90.8%	NA
Tooth Surface 1	9.2%	0.0%	90.8%	NA
Tooth Surface 2	5.9%	0.0%	94.1%	NA
Tooth Surface 3	1.9%	0.0%	98.1%	NA
Tooth Surface 4	0.5%	0.0%	99.5%	NA

Key Data Elements	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
Tooth Surface 5	0.1%	0.0%	99.9%	NA
Oral Cavity Code 1-5[6]	<0.1%	<0.1%	98.8%	92.5%
Oral Cavity Code 1	<0.1%	<0.1%	98.8%	92.5%
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%	98.6%
Header Paid Amount	0.0%	0.0%	0.0%	>99.9%

[1] Element Omission displays the percentage of records with values present in the **Delta Dental**'s submitted files but not in HHS' submitted files.

[2] Element Surplus displays the percentage of records with values present in HHS' submitted files but not in the **Delta Dental**'s submitted files.

[3] Element Missing Values displays the percentage of records with values missing from both HHS' submitted files and **Delta Dental**'s submitted files.

[4] Element Accuracy displays the percentage of records with the values present and having identical values in both **Delta Dental**'s submitted files and HHS' submitted files.

[5] The results are derived from comparing all five tooth surface field values that were submitted.

[6] The results are derived from comparing all five oral cavity code field values that were submitted.

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

Table 4-15 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 4-15—All-Element Accuracy: DDIA

Number of Records in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
1,891,134	1,459,655	77.2%

Note: The denominator for the all-element accuracy rate is defined differently from the denominators for the individual element accuracy rates since it includes data elements even if values are missing in both sources. If any of the data elements are an element omission, element surplus, or an inaccurate value match, the record will not be a positive hit for the all-element accuracy numerator.

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' MMIS, suggesting a potential gap in the transmission of data to HHS through encounter submissions. [**Quality**]

Why the weakness exists: Although this finding was a weakness identified through **Delta Dental**'s EDV activity, the weakness is not specific to **Delta Dental**'s processes. The root cause lies within HHS' MMIS system, necessitating resolution.

Recommendation: Although **Delta Dental** has initiated discussions on these discrepancies with HHS, HSAG recommends continued collaboration to actively address and resolve the issue, ensuring accurate and complete data transmission for tooth surface information.

Weakness #2: When *Oral Cavity Code* values were compared to values within HHS' data, some values did not match. [**Quality**]

Why the weakness exists: **Delta Dental**-submitted data had fewer detail lines than the corresponding HHS-submitted data, resulting in a misalignment in the population of data elements.

Recommendation: HSAG recommends that **Delta Dental** submit all the detail lines for each claim to ensure a comprehensive and aligned representation of data elements, minimizing discrepancies in *Oral Cavity Code* values.

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 PAHP Quality Strategy goals and objectives. Table 4-16 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 and Hawki members.

Table 4-16—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Network Adequacy and Availability of Services	**Timeliness and Access**—For the CY 2023 NAV activity, a secret shopper survey was completed to collect dental cleaning appointment availability for Medicaid patients new to a provider location. While many provider locations could be contacted and most provider locations that were contacted offered dental services, **Delta Dental**'s NAV results also indicate opportunities for improvement. **Delta Dental**'s provider network data included inaccurate information regarding the provider location's acceptance of the PAHP, Medicaid, and new patients; of the locations reached, only 54.7 percent of provider locations accepted **Delta Dental**, 48.9 percent accepted Medicaid, and 40.1 percent accepted new patients. Further, of the locations reached, the appointment availability was only 24.8 percent, with an average wait time of 55 calendar days. These results indicate that **Delta Dental**'s members may be experiencing barriers to care such as inaccurate provider information, procedural barriers to scheduling appointments, and long wait times for appointments. In support of Goal 1 of the PAHP Quality Strategy, and specifically Objective 1.3, **Delta Dental** should consider strategies to improve the accuracy of provider information that is available to members and conduct its own secret shopper surveys to ensure that members have timely access to dental care and services. Secret shopper surveys would also provide **Delta Dental** with trending data over time to monitor positive or negative trends in accessing dental services. **Delta Dental** should use the results to explore potential barriers and identify interventions that could be implemented to increase dental care utilization (i.e., performance measure rates and PIP performance indicator rates). Additionally, for the *Members Who Accessed Dental Care* performance measure, **Delta Dental** demonstrated a slight decline for the DWP Adults population over the past three years, with the CY 2023 rate at 29.02 percent. Further, as reported through the *Providers Seeing Patients* performance measure for the DWP Kids population, **Delta Dental** had 762 of 900 (84.67 percent) providers who actively saw members; however, a prior year's rate for comparison is not available, as CY 2023 was the first year this measure was validated through the PMV activity. **Delta Dental** should focus improvement efforts on these measures to advance Goal 1 of the PAHP Quality Strategy, specifically Objectives 1.1 and 1.2, to ensure the DWP program meets HHS' CY 2024 goals. **Delta Dental** also continued its PIP, *Annual Preventative Dental Visits*, during CY 2023. While the rate for DWP Adult members demonstrated a minimal decline from its baseline rate, the rate for DWP Kids and Hawki members demonstrated statistically significant improvement from the prior year. In an effort to increase the number of adults and children receiving a preventive dental visit, **Delta Dental** improved member services' processes; outreached to members to provide education on their benefits, assist members with locating a provider, and encourage members to update contact information; mailed dental kits; and partnered with a tele-dentistry provider.

Performance Area	Overall Performance Impact
Prevention and Recall Services	**Quality** and **Access**—The results from the CY 2023 PMV activity for the *Members Who Received Preventive Dental Care* and *Members Who Received a Preventive Examination and a Follow-Up Examination* performance measures indicate that **Delta Dental** has made some progress in increasing the utilization of preventive and follow-up dental care both for its DWP and Hawki populations. The rate for DWP Adults who received preventive dental care increased by 3.28 percentage points from the prior year, although it was slightly below the CY 2021 rate. For the DWP Kids population, the rate of children who received preventive dental care increased by 3.95 percentage points from the prior year, and the rate for the Hawki population increased by 4.98 percentage points. Additionally, more DWP Adult members received a preventive dental examination and a follow-up examination over the past three years (CYs 2021, 2022, and 2023), as demonstrated by rates of 54.79 percent, 59.69 percent, and 60.64 percent, respectively. According to the World Health Organization, most oral health conditions, such as dental caries, periodontal diseases, tooth loss, and oral cancer, are largely preventable and can be treated in their early stages. While **Delta Dental** is making progress toward increasing the rate of Hawki members who receive preventive dental care and increasing the rate of DWP Adult members who receive follow-up dental care, additional attention is needed to help HHS reach its SFY 2024 targets for Objectives 2.1 and 2.2 within the PAHP Quality Strategy. Through the CY 2023 PMV activity, it was also noted that **Delta Dental** closely monitored performance of measures and compared performance against its PIPs and QAPI program to identify opportunities for improvement. **Delta Dental** should continue current efforts to increase the number of members receiving dental care services and continually explore additional interventions that could be implemented in support of Goal 2 of the PAHP Quality Strategy.
Health Information Systems and Technology	Through the CY 2023 PMV activity, **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. While a minor concern with source code logic and measure specification adherence was identified for one measure, **Delta Dental** was able to update its source code per the specification. HSAG determined that **Delta Dental**'s data integration and measure reporting processes were adequate and ensured data integrity and accuracy, and the PAHP received a measure designation of *Reportable* for all performance measures included in the PMV activity. Additionally, **Delta Dental**'s encounter data appeared complete when comparing data extracted from the PAHP'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. The comparison also showed complete and accurate data for most data elements evaluated. However, when *Oral Cavity Code* values were compared to values within

Performance Area	Overall Performance Impact
	HHS' data, some values did not match. **Delta Dental** should submit all the detail lines for each claim to ensure a comprehensive and aligned representation of data elements, minimizing discrepancies in *Oral Cavity Code* values. Further, while **Delta Dental** previously failed to implement CMS' application programming interface (API) requirements, the CY 2023 compliance review activity confirmed implementation of the Patient Access and Provider Directory APIs. However, **Delta Dental** had not yet developed educational materials explaining the availability of the Patient Access API, such as the required member-facing webpage; had not developed a public-facing webpage explaining how third-party vendors can access the APIs to make health information available to members; and while the Provider Directory API was available to stakeholders upon request, **Delta Dental** had not made it accessible via a public-facing digital endpoint on its website to ensure public discovery and access. **Delta Dental** must ensure that it implements all requirements of the APIs described in the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). Further, CMS has enhanced interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). As such, **Delta Dental** should begin preparing for the development and implementation of these new requirements.

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, Implementation, and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 4-17 displays the overall validation rating and the baseline and Remeasurement 1 results for each performance indicator.

Table 4-17—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%	60.19% ↓	
		2. The percentage of members 18 years of age and younger who had at least one preventive dental visit during the measurement year.	35.86%	37.88% ↑	

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* The PIP activities for CY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for CY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PAHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

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 4-18 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the PAHP to support achievement of the PIP goals and address the barriers.

Table 4-18—Remeasurement 1 Barriers and Interventions for MCNA

Barriers	Interventions
Member's lack of knowledge of benefit coverage, lack of knowledge about the importance of routine dental checkups and its ability to prevent oral diseases, and their lack of knowing of the need to see a dentist when not in pain.	Conduct outbound calls to members who have not completed a preventive dental visit to educate them on their available benefits for dental checkups as well as the importance of routine dental care to prevent further problems such as gum disease. Members are also encouraged to schedule an appointment and offered assistance if needed.
	Members who have not received a preventive service within the last six months receive an educational postcard educating them on the importance of preventive services and encouraging them to schedule a preventive checkup.
Low provider reimbursement rates as compared to program administrative costs.	Providers receive an additional $10 when they see members for a recall visit.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MCNA Dental met 100 percent of the requirements for data analysis and implementation of improvement strategies. The PAHP conducted accurate statistical testing comparing the Remeasurement 1 outcomes to the baseline performance and provided a narrative interpretation of that comparison. **MCNA Dental** used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers. Intervention evaluation results were provided for each intervention effort. [**Quality**, **Timeliness**, and **Access**]

Strength #2: MCNA Dental demonstrated statistically significant improvement for the second performance indicator and demonstrated clinically significant improvement through interventions initiated during the measurement period. The interventions, an outbound call campaign and preventive dental care postcard reminders, increased the percentage of members completing a preventive dental visit within 60 days of receiving the intervention. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: **MCNA Dental** demonstrated a statistically significant decline in performance for the first performance indicator. [**Quality** and **Access**]

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

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

Performance Measure Validation

Performance Results

HSAG reviewed **MCNA Dental**'s membership/eligibility data system, encounter data processing system, provider data 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 4-19 displays measure designation and reportable measure rates for DWP Adults, and Table 4-20 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 4-19—2023 MCNA Performance Measure Designations and Rates for DWP Adults

	Performance Measure	2021 Rate	2022 Rate	2023 Measure Designation	2023 Results		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	138,535	160,048	*R*	174,100	—	—
2	*Members Who Accessed Dental Care*	18.57%	17.29%	*R*	174,100	27,855	16.00%
3	*Members Who Received Preventive Dental Care*	65.11%	61.70%	*R*	27,855	16,898	60.66%

Performance Measure		2021 Rate	2022 Rate	2023 Measure Designation	2023 Results		
					Denominator	Numerator	Rate
4	*Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation*	12,499	13,729	*R*	14,819	—	—
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*	4,288	5,439	*R*	—	6,156	—
6	*Members Who Received a Preventive Examination and a Follow-Up Examination*	34.31%	39.62%	*R*	14,819	6,156	41.54%

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

Table 4-20—2023 MCNA Performance Measure Designations and rates for DWP Kids

Performance Measure		2022 Rate	2023 Measure Designation	2023 Results		
				Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	122,314	*R*	125,471	—	—
3	*Members Who Received Preventive Dental Care*	35.86%	*R*	125,471	48,091	38.33%
7	*Providers Seeing Patients*	**	*R*	196	125	63.78%

— A dash indicates a value is not applicable to the performance measure.
**The measure was not yet published in the MY.

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 providers 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 has implemented initiatives to improve performance on quality measures. At the member level, **MCNA Dental** implemented communication campaigns using various methods of outreach and trended the intervention's success. At the provider level, **MCNA Dental** has launched an incentive program to reward timely follow-up and rendering of preventive oral services. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: During PSV, **MCNA Dental** was unable to reproduce an exact query output in comparison to the data set submission to HSAG for the *Providers Seeing Patients* measure. The query output during PSV contained a few variations in the number of patients associated with specific providers. [**Quality**]

Why the weakness exists: MCNA Dental indicated that the variations in the query output during the virtual review occurred due to a lack of clarity in the HHS reporting template instructions that impacted identification of the denominator for the measure.

Recommendation: HSAG recommends that **MCNA Dental** notify the State when it identifies that State-specific reporting requirements may be unclear and could lead to multiple interpretations. HSAG also recommends that **MCNA Dental** maintain query outputs for data set submissions. Recorded output documentation and inclusion of patient-level details will provide **MCNA Dental** with the opportunity to conduct a root cause analysis and validate data set submission deviations if future concerns are noted.

Weakness #2: MCNA Dental's rates for the *Members Who Accessed Dental Care* and *Members Who Received Preventive Dental Care* measures decreased gradually in 2022 and 2023. [**Access**]

Why the weakness exists: MCNA Dental's total number of *Members With at Least Six Months of Coverage* increased in 2022 and 2023; however, the rate of *Members Who Accessed Dental Care* and *Members Who Received Preventive Dental Care* both decreased, indicating that **MCNA Dental**'s newer members were not accessing dental care proportionately within their first six months to one year of eligibility.

Recommendation: HSAG recommends that **MCNA Dental** conduct a segmentation analysis of the noncompliant members to identify trends in demographics for the noncompliant population. HSAG also recommends that **MCNA Dental** identify targeted interventions to increase knowledge and awareness of dental care benefits for members within their first year of eligibility.

Compliance Review

Performance Results

Table 4-21 presents an overview of the results of the CY 2021 and CY 2022 compliance reviews for **MCNA Dental**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements (i.e., requirements) it reviewed. If a requirement was not applicable to **MCNA Dental** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

Table 4-21—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	6	6	6	0	0	**100%**
Standard II—Member Rights and Member Information	18	17	15	2	1	**88%**
Standard III—Emergency and Poststabilization Services	10	10	10	0	0	**100%**
Standard IV—Availability of Services	7	7	7	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	4	4	4	0	0	**100%**
Standard VI—Coordination and Continuity of Care	7	7	6	1	0	**86%**
Standard VII—Coverage and Authorization of Services	10	10	10	0	0	**100%**
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[1]	13	13	13	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	10	8	8	0	2	**100%**
Total	**155**	**150**	**143**	**7**	**5**	**95%**

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] This standard includes a comprehensive assessment of the MCP's IS capabilities.

Based on the findings of the CY 2021 and CY 2022 compliance review activities, **MCNA Dental** was required to develop and submit a CAP for each element assigned a score of *Not Met*. HHS and HSAG reviewed the CAP for sufficiency, and **MCNA Dental** was responsible for implementing each action plan in a timely manner. Table 4-22 presents an overview of the results of the CY 2023 compliance review for **MCNA Dental**, which consisted of a comprehensive review of the PAHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 4-22—Summary of CAP Implementation

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard II—Member Rights and Member Information	2	2	**0**
Standard VI—Coordination and Continuity of Care	1	0	**1**
Standard X—Grievance and Appeal Systems	2	2	**0**
Standard XI—Subcontractual Relationships and Delegation	2	2	**0**
Total	**7**	**6**	**1**

Total CAP Elements: The total number of elements within each standard that required a CAP during the CY 2021 and CY 2022 compliance review activities.
# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.
# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

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 demonstrated that it successfully remediated six of seven elements, indicating the necessary policies, procedures, and initiatives were implemented and demonstrated compliance with the requirements under review. Further, **MCNA Dental** remediated all elements for three of the four standards reviewed: Member Rights and Information, Grievance and Appeal Systems, and Subcontractual Relationships and Delegation. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: MCNA Dental did not remediate the one CAP element for the Coordination and Continuity of Care standard, indicating a continued gap in the PAHP's processes to ensure that members complete the initial health risk screening in a timely manner. [**Quality** and **Timeliness**]

Why the weakness exists: Although **MCNA Dental** made some progress toward implementing its CAP for conducting subsequent outreach attempts to members who have not completed an oral health risk self-assessment within 90 days of the member's enrollment, the PAHP was not using internally developed reports to identify members who have not yet completed the initial screening or making subsequent attempts to contact the members within 90 days of enrollment.

Recommendation: HSAG required **MCNA Dental** to submit an updated action plan indicating that the PAHP had fully implemented interventions to maximize efforts to ensure members complete the initial health risk screening in a timely manner. As such, HSAG recommends that **MCNA Dental** continue to implement its new outreach procedures and use internal data to track and subsequently increase the number of members who complete the initial health risk screening within 90 calendar days of enrollment.

Network Adequacy Validation

Performance Results

Through the secret shopper survey, HSAG attempted to contact 177 sampled provider locations (i.e., "cases") for **MCNA Dental**, with an overall response rate of 84.7 percent (150 cases) among **MCNA Dental**'s two programs. Table 4-23 summarizes the CY 2023 secret shopper survey response rates for **MCNA Dental** and for each of **MCNA Dental**'s enrolled programs.

Table 4-23—Summary of MCNA Secret Shopper Survey Results for Routine Dental Visits, by Program

Program	Response Rate		Offering Dental Services		Accepting PAHP		Accepting Iowa Medicaid	
	Cases Reached	Rate (%)[1]	Offering Dental Services	Rate (%)[2]	Accepting PAHP	Rate (%)[2]	Accepting Iowa Medicaid	Rate (%)[2]
DWP Adults	98	84.5%	91	92.9%	72	73.5%	66	67.3%
DWP Kids	52	85.2%	48	92.3%	38	73.1%	33	63.5%
MCNA Total	**150**	**84.7%**	**139**	**92.7%**	**110**	**73.3%**	**99**	**66.0%**

[1] The denominator includes all sampled providers.
[2] The denominator includes cases reached.

Table 4-24 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **MCNA Dental** and for each of **MCNA Dental**'s enrolled programs. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 4-24—Summary of MCNA Secret Shopper Survey Appointment Availability Results, by Program

Program	Accepting New Patients		Cases Offered an Appointment		Appointment Wait Time (Calendar Days)
	Number	Rate(%)[1]	Number	Rate(%)[1]	Average
DWP Adults	37	37.8%	16	16.3%	85
DWP Kids	20	38.5%	12	23.1%	46
MCNA Total	**57**	**38.0%**	**28**	**18.7%**	**68**

[1] The denominator includes cases reached.

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: Of the 177 total survey cases, 84.7 percent (n=150) of the provider locations could be contacted. **[Quality** and **Access]**

Strength #2: Of the cases reached, 92.7 percent of provider locations offered dental services. **[Access]**

Weaknesses and Recommendations

Weakness #1: Of the cases reached, 73.3 percent of provider locations accepted **MCNA Dental**, 66.0 percent accepted Medicaid, and 38.0 percent accepted new patients. **[Access]**

Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **MCNA Dental**'s data included inaccurate information regarding the provider location's acceptance of **MCNA Dental**, Medicaid, and new patients.

Recommendation: HSAG recommends that **MCNA Dental** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect Medicaid acceptance and new patient acceptance) to address the provider data deficiencies and educate provider offices on the Medicaid program. Additionally, **MCNA Dental** should adhere to any remediation requirements imposed by HHS.

Weakness #2: Among the cases reached, the overall appointment rate was 18.7 percent, with an overall average wait time of 68 calendar days for **MCNA Dental**. **[Access]**

Why the weakness exists: For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included being required to complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **MCNA Dental** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **MCNA Dental** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Table 4-25 displays the percentage of records present in the files submitted by the **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).

Table 4-25—Record Omission and Surplus for MCNA

Record Omission	Record Surplus
14.3%	5.9%

Table 4-26 displays the element omission, element surplus, element missing values and element accuracy indicator 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. For element accuracy, higher rates indicate better performance. However, for the element missing values indicator, lower or higher rates do not indicate better or worse performance.

Table 4-26—Element Omission, Surplus, Missing Values, and Accuracy: MCNA

Key Data Elements	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
Member ID	0.0%	0.0%	0.0%	100.0%

Key Data Elements	Element Omission[1]	Element Surplus[2]	Element Missing Values[3]	Element Accuracy[4]
Header Service From Date	0.0%	0.0%	0.0%	99.8%
Header Service To Date	0.0%	0.0%	0.0%	99.8%
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%	94.1%
Rendering Provider NPI	0.0%	0.0%	0.0%	100.0%
CDT Code	0.0%	0.0%	0.0%	95.2%
Units of Service	0.0%	0.0%	0.0%	98.8%
Tooth Number	1.8%	0.4%	71.9%	96.3%
Tooth Surface 1-5[5]	0.8%	0.1%	89.9%	98.9%
Tooth Surface 1	0.8%	0.1%	89.9%	99.0%
Tooth Surface 2	0.3%	0.1%	94.7%	99.4%
Tooth Surface 3	0.1%	<0.1%	98.2%	99.5%
Tooth Surface 4	<0.1%	<0.1%	99.5%	99.8%
Tooth Surface 5	<0.1%	<0.1%	99.9%	99.8%
Oral Cavity Code 1-5[6]	0.1%	<0.1%	99.0%	96.5%
Oral Cavity Code 1	0.1%	<0.1%	99.0%	96.5%
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%	94.6%
Header Paid Amount	0.0%	0.0%	0.0%	95.7%

[1] Element Omission displays the percentage of records with values present in the **MCNA Dental**'s submitted files but not in HHS' submitted files.

[2] Element Surplus displays the percentage of records with values present in HHS' submitted files but not in the **MCNA Dental**'s submitted files.

[3] Element Missing Values displays the percentage of records with values missing from both HHS' submitted files and **MCNA Dental**'s submitted files.

[4] Element Accuracy displays the percentage of records with the values present and having identical values in both **MCNA Dental**'s submitted files and HHS' submitted files.

[5] The results are derived from comparing all five tooth surface field values that were submitted.

[6] The results are derived from comparing all five oral cavity code field values that were submitted.

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

Table 4-27 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 4-27—All-Element Accuracy: MCNA

Number of Records in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
605,930	508,472	83.9%

Note: The denominator for the all-element accuracy rate is defined differently from the denominators for the individual element accuracy rates since it includes data elements even if values are missing in both sources. If any of the data elements are an element omission, element surplus, or an inaccurate value match, the record will not be a positive hit for the all-element accuracy numerator.

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 were identified in the data files extracted for the study, specifically with **MCNA Dental**-submitted encounters, which included encounters not in their final status, as had been requested. Consequently, these errors resulted in discrepancies when compared to the HHS-submitted data. [**Quality**]

Why the weakness exists: **MCNA Dental** did not extract the encounters that were in their final status as per the study's requirements.

Recommendation: HSAG recommends that **MCNA Dental** enhance its standard quality controls to ensure accurate data extraction in alignment with study requirements. Through the development of standardized data extraction procedures and robust quality control measures, **MCNA Dental** can mitigate errors associated with extracted data.

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 PAHP Quality Strategy goals and objectives. Table 4-28 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**'s Medicaid and Hawki members.

Table 4-28—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Network Adequacy and Availability of Services	**Timeliness and Access**—For the CY 2023 NAV activity, a secret shopper survey was completed to collect dental cleaning appointment availability for Medicaid patients new to a provider location. While many provider locations could be contacted and most provider locations offered dental services, **MCNA Dental**'s NAV results also indicate opportunities for improvement. **MCNA Dental**'s provider network data included inaccurate information regarding the provider location's acceptance of the PAHP, Medicaid, and new patients; of the locations reached, only 73.3 percent of provider locations accepted **MCNA Dental**, 66 percent accepted Medicaid, and 38 percent accepted new patients. Further, of the locations reached, the appointment availability was only 18.7 percent, with an average wait time of 68 calendar days. These results indicate that **MCNA Dental**'s members may be experiencing barriers to care, such as inaccurate provider information, procedural barriers to scheduling appointments, and long wait times for appointments. In support of Goal 1 of the PAHP Quality Strategy, specifically Objective 1.3, **MCNA Dental** should consider strategies to improve the accuracy of provider information that is available to members and conduct its own secret shopper surveys to ensure members have timely access to dental care and services. Annual or routinely scheduled secret shopper surveys would also provide **MCNA Dental** with trending data over time to monitor positive or negative trends in accessing dental services. **MCNA Dental** should use the results to explore potential barriers and identify interventions that could be implemented to increase dental care utilization (i.e., performance measure rates and PIP performance indicator rates). Additionally, for the *Members Who Accessed Dental Care* performance measure, **MCNA Dental** demonstrated a decline for the DWP Adults population over the past three years, with the CY 2023 rate at 16 percent. Further, as reported through the *Providers Seeing Patients* performance measure for the DWP Kids population, **MCNA Dental** had 125 of 196 (63.78 percent) providers who actively saw members; however, a prior year's rate for comparison is not available, as CY 2023 was the first year this measure was validated through the PMV activity. **MCNA Dental** should focus improvement efforts on these measures to advance Goal 1 of the PAHP Quality Strategy, specifically Objectives 1.1 and 1.2, to ensure that the DWP program meets HHS' CY 2024 goals.

Performance Area	Overall Performance Impact
Prevention and Recall Services	**Quality** and **Access**—The results from the CY 2023 PMV activity for the *Members Who Received Preventive Dental Care* and *Members Who Received a Preventive Examination and a Follow-Up Examination* performance measures indicate that **MCNA Dental** has made some progress toward increasing the utilization of preventive and follow-up dental care. The rate for DWP Kids who received preventive dental care increased by 2.47 percentage points from the prior year. Additionally, more DWP Adult members received a preventive dental examination and a follow-up examination over the past three years (CYs 2021, 2022, and 2023), as demonstrated by rates of 34.31 percent, 39.62 percent, and 41.54 percent, respectively. According to the World Health Organization, most oral health conditions, such as dental caries, periodontal diseases, tooth loss, and oral cancer, are largely preventable and can be treated in their early stages. **MCNA Dental** also continued its PIP, *Increase the Percentage of Dental Services*, during CY 2023, which demonstrated mixed results. While the rate of members 18 years of age and younger who received at least one preventive dental visit demonstrated a statistically significant improvement over the baseline, the rate of members 19 years of age and older demonstrated a statistically significant decline. In an effort to increase the number of members receiving a preventive dental visit, **MCNA Dental** outreached to members to provide education on their benefits and offered assistance in scheduling an appointment. **MCNA Dental** also paid providers an incentive when they saw members for a recall visit. **MCNA Dental** should consider additional barriers the adult population may be experiencing in accessing dental care. While **MCNA Dental** is making some progress toward increasing the rate of members who receive preventive dental care and increasing the rate of members who receive follow-up dental care, additional attention is needed to help HHS reach its CY 2024 targets for Objectives 2.1 and 2.2 within the PAHP Quality Strategy.
Health Information Systems and Technology	Through the CY 2023 PMV activity, **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. HSAG determined that **MCNA Dental**'s data integration and measure reporting processes were adequate and ensured data integrity and accuracy, and the PAHP received a measure designation of *Reportable* for all performance measures included in the PMV activity. Additionally, **MCNA Dental**'s encounter data showed complete and accurate data for most data elements evaluated when comparing data extracted from the PAHP's claims systems to data extracted from HHS' data warehouse. However, errors were identified in the data files extracted for the study, specifically with **MCNA Dental**-submitted encounters, which included encounters not in their final status, as had been requested. Consequently, these errors resulted in discrepancies when compared to the HHS-submitted data. **MCNA Dental** should enhance its standard quality controls to ensure accurate data extraction in alignment with study requirements to mitigate errors associated with extracted data.

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the CY 2023 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Iowa Managed Care Program. The recommendations provided to each MCO for the EQR activities in the *Calendar Year 2022 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 Improvement Projects:
HSAG recommended the following: • HSAG did not identify any substantial weaknesses for **Amerigroup** through the PIP activity. Therefore, no recommendations were made.
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)***:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG Assessment: HSAG did not identify any substantial weaknesses for **Amerigroup** through the PIP activity. Therefore, no recommendations were made, and this section is not applicable.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: **PMV Results** • **Amerigroup** did not include encounter data from its waiver transportation vendor in preliminary rates for measure 1. **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. 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.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• **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. **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. **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 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.
HEDIS Results
• **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. 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. **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.
• **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. 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. 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.,

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
process improvements, patient education campaign, and 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 Results • **Amerigroup** has corrected the omission of waiver transportation encounters and these encounters are now integrated into other Long-Term Services and Supports (LTSS) claims during evaluation processes. • We will continue to improve and implement updates to the Healthy Innovations Platform (HIP) system, and we will explore data extraction capabilities with new versions of the HIP system. The Habilitation and Children's Mental Health Waiver data will continue to be a manual activity due to these care plans and documentation housed within the Integrated Health Homes. HEDIS Results • **Amerigroup** will continue educational efforts with providers to include women's health and cultural competency. • Behavioral health (BH) Quality Incentive Programs that focus on mental health (MH) • We are in process of identifying providers that treat the severe and persistently mentally ill (SPMI) population to provide assist in the purchase of testing equipment to use for diabetes and cholesterol screening within the practice. • We will be monitoring two HEDIS measures: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD) and Metabolic monitoring for children and adolescents on antipsychotics (APM) • We are identifying Pediatricians and Child psychiatrists to work with on the attention-deficit/hyperactivity disorder (ADHD). • Collaboration with providers in Integrated Health Homes • Provider education via email, BH Webinars and other BH/HEDIS related collaterals on ADHD, Follow-Up After Mental Illness (FUH), Follow-Up After Emergency Department Visit for Alcohol & Other Drug Abuse or Dependence (FUA), Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) and other BH related HEDIS measures. • We work with mobile BH/MH Counselors and other BH providers in providing telehealth services. • Collaborate with pharmacy on member adherence via provider and member outreach. • Member short message service (SMS) (text) campaigns. • Member Healthy Rewards, our member incentive program to encourage utilization of health services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV • Waiver transportation encounters were added during the PMV audit, and the results were then supplemented with the additional information. HEDIS • TBD

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

c. Identify any barriers to implementing initiatives:

PMV

- No barriers.

HEDIS

- Final approval for the BH mini-lab testing collaterals to share with providers are pending approval.

HSAG Assessment: HSAG has determined that **Amerigroup** partially addressed the prior year's recommendations. **Amerigroup** performance improved on the waiver transportation encounters; however, results from the current EQR indicate that the initiatives were not effective in supporting quality improvement or were not initiated early enough in the measurement year to make an impact on the rate. For example**,** the *Chlamydia Screening in Women* measure rate increased by less than 1 percentage point in MY 2022, and the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure rate increased by just over 1 percentage point in MY 2022. **Amerigroup** has ongoing opportunities for improvement on measures related to the Women's Health and Behavioral Health domains. HSAG recommends that **Amerigroup** continue to focus on improvement strategies for those measures that continued to demonstrate low performance. Further, initiatives related to the automated extraction of care coordination data from the Healthy Innovations Platform have not been implemented per the recommendations, as **Amerigroup** noted its desire to wait for a system upgrade.

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

HSAG recommended the following:

- **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. **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. **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.

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)***:

- Remediation activities were implemented to ensure timely credentialing notification letters are sent and reporting is accurate.

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

- Corrective action plan steps were implemented and completed resulting in timely notification and accurate credentialing reports.

c. Identify any barriers to implementing initiatives:

- No barriers.

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

HSAG Assessment: HSAG has determined that **Amerigroup** addressed the prior year's recommendations. The CY 2023 compliance review activity confirmed that the MCO successfully remediated all deficiencies within the Provider Selection standard.

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

HSAG recommended the following:

- HSAG did not identify any substantial weaknesses for **Amerigroup** through the NAV activity. Therefore, no recommendations were made.

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)***:

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

c. Identify any barriers to implementing initiatives:

HSAG Assessment: HSAG did not identify any substantial weaknesses for **Amerigroup** through the NAV activity. Therefore, no recommendations were made, and this section is not applicable.

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

HSAG recommended the following:

Medical Record Review:

- **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. 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. **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.
- No documentation/medical records were available for the selected members' dates of service. 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. **Amerigroup** should investigate and follow up with its providers to determine why encounters were submitted to HHS but no documentation/medical records were available

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

for the requested dates of service. Based on the findings, **Amerigroup** should consider taking additional action, as appropriate (e.g., request overpayment of funds).

- 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. 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. 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.

MCP's Response

- 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

- Action steps were outlined for subsequent medical record review activities. **Amerigroup** to meet internally regularly during the record collection timeframe to direct needed follow up and claims research; increase number of follow ups and variety of communication channels; include health plan associates in individual provider follow up when necessary; suggest revisions to medical record collection tool to indicate specifically any non-submission reasons.
- Provider agreement templates are regularly reviewed for improvements and the recommendations will be considered for provider agreement template revisions.

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

- N/A. Medical record review not a part of the Encounter Data Validation in current year.

c. Identify any barriers to implementing initiatives:

- No barriers.

HSAG Assessment: HSAG has determined that **Amerigroup** addressed the prior year's recommendations, as indicated by the action plans noted in the MCO's response. However, based on **Amerigroup**'s response, HSAG recommends that the MCO continue monitoring and evaluating the effectiveness of the implemented initiatives over time. Regular reviews of provider agreement templates and ongoing communication with providers may help sustain improvement. Additionally, as the medical record review was not part of the CY 2023 EDV, it is essential to ensure that the lessons learned and actions taken are seamlessly integrated into future validation processes. It may also be beneficial for **Amerigroup** to consider periodic assessments of provider compliance with documentation requirements and coding practices to maintain a proactive approach to data accuracy and completeness. Overall, **Amerigroup**'s response indicates a commitment to addressing the identified issues and improving the accuracy and completeness of encounter data.

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

HSAG recommended the following:

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

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)***:

- Member SMS campaign (text)
- Smoking assistance question on Health Risk Assessment form
- Case Managers offer smoking cessation assistance with patients /care planning
- Provider Education and resources on **Amerigroup** Smoking cessation program to all members
- Provide Smoking cessation information in Member and Provider Handbook

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

- N/A - TBD

c. Identify any barriers to implementing initiatives:

- Delay in member identification due to member redetermination and redistribution
- Approval of the member SMS (text) campaign
- State approval to change smoking cessation program/subcontractor

HSAG Assessment: HSAG has determined that **Amerigroup** addressed the prior year's recommendation, as rates for two of the three Medical Assistance With Smoking and Tobacco Use measures, *Discussing Cessation Medications* and *Discussing Cessation Strategies*, were not statistically significantly lower than the 2022 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:

- HSAG did not identify any substantial weaknesses for **Iowa Total Care** through the PIP activity. Therefore, no recommendations were made.

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)***:

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

c. Identify any barriers to implementing initiatives:

HSAG Assessment: HSAG did not identify any substantial weaknesses for **Amerigroup** through the PIP activity. Therefore, no recommendations were made, and this section is not applicable.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

HSAG recommended the following:

PMV Results:

- **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. **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. 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.
- **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. **Iowa Total Care** had not yet completed migration of Access2Care waiver transportation encounter data into its data warehouse. **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.

HEDIS Results:

- **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

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

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. 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. 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.

- **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. 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. 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.

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 Results:

- **Iowa Total Care** (**ITC**) was able to fully implement the Person-Centered Service Plan (PCSP) in TruCare Anywhere (TCA) and TruCare Classic (TC) as an electronic document as of 3/1/2023. **ITC** will be phasing out the word doc copy of the PCSP over the next several months. As new annual PCSPs are created case managers will enter all data into the electronic version. TCA is used on Chromebook and does not rely on internet connectivity. The case manager can download TruCare "assessments" to the Chromebook TCA application, complete them with the member, and upload them to TruCare when they have an established

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

internet connection. Once uploaded to TruCare, case managers have a PDF document to share with members, guardians, providers, etc., while also having an electronic version in TruCare that **ITC** can pull reports directly from this assessment.

- **ITC** is working to collect and store external vendor encounter data from Access2Care into our Enterprise Data Warehouse (EDW). The purpose was to be able to collect and load the data to the EDW and then fully automate reporting of Long Term Services and Support (LTSS)/Waiver transportation encounter data and eliminate the use of manual processes to produce the reports. Once the build is complete and the data loaded into the EDW, **ITC** will be able to fully implement an automated report that will provide LTSS/Waiver transportation encounter data reports and move away from the current manual process.

HEDIS Results:

- Women's Health - **Iowa Total Care** is constantly working to improve its population health program to meet the needs of our members. **Iowa Total Care** has increased the ability to capture and report on member race, ethnicity, and language for our membership. This has been accomplished through the enhancements of the ingestion of our state membership file, our ability to utilize E Tech and census data, and increase member self-reported information. This includes evaluating the effectiveness of interventions and making changes as needed. **Iowa Total Care** uses data to identify populations and to target interventions accordingly. **Iowa Total Care** completed a measure deep dive analysis of the Breast Cancer Screening measure. Member race, age and geographic location with high non-compliant concentration was identified. Potential opportunities of improvement were identified, and interventions were continued and or implemented to impact performance improvement.
  - **Iowa Total Care** implemented a Women's 360 texting program in July 2022 to improve member engagement and to close care gaps related to women's health. In September, a breast cancer screening reminder text was sent to 4,459 members who were due or overdue for a breast cancer screening.
  - **Iowa Total Care** offers a provider incentive program designed to improve & reward providers' performance around patients' health care & the specific activities related to closing care gaps for breast cancer screenings.
  - **Iowa Total Care** has registered nurses involved in a Face-to-Face provider engagement program to educate providers on HEDIS Measures (BCS) and provide reference guides as well as gap-in-care reports to providers through the **Iowa Total Care** secure portal.
  - Educational materials for members and providers available on **Iowa Total Care** website are promoted through provider engagement meetings and community outreach events.
  - The member rewards program, My Health Pays, is designed to incentivize members to complete healthy activities for dollar rewards. The $20 reward – earned once per calendar year for completion of breast cancer screening.
  - Education aimed to improve health disparities in partnership to our community partners (federally qualified health centers [FQHCs], rural health clinics [RHCs], primary care providers [PCPs]/obstetrics and gynecologists [OBGYNs], Doulas, Midwives) through community newsletters, websites, and Stakeholder Advisory Board. In 2022, **Iowa Total Care** shared instances of Cultural Competency and Health Equity education within the provider newsletter quarterly and we worked closely with our community partners such as the Refugee Alliance of Central Iowa, NAMI, Iowa Bureau of Refugee Services, Latinx Community to educate on the importance of Women's preventive health and awareness.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

- Additional analysis did identify limited or inadequate transportation to services in rural areas, **Iowa Total Care** is currently working on implementing transportation resources in identified areas of need to close care gaps due to transportation needs.
- **Iowa Total Care** completed an analysis of the data to identify opportunities to help eliminate or mitigate barriers to completing or reporting timely prenatal care. The following are a highlight of the interventions identified and implemented.
  - Implementation of pilot Doula program
  - Go before you show member education campaign.
  - My Health Pays Reward for completing prenatal visit in first trimester.
  - PPC Provider Coding incentive
  - Provider Pay for Performance
  - Implementation of year-round medical record review including track and trending report for providers on practice improvements regarding EMR documentation and office practices for prenatal and postpartum appointments

- Behavioral Health Domain—**Iowa Total Care** continues to work closely with our Primary care, Health home and Behavioral health provider partners. In review of the lower performing measures **Iowa Total Care** was able to identify barriers:
  - Provider Lack of measure understanding of HEDIS metrics (timeline, required provider types, and documentation needed to close metric)
  - Provider Coding completeness and/or accuracy for point of service, encounter, or Service coding
  - Lack of awareness of required laboratory monitoring for certain medications and diagnosis

- By identifying the above barriers **ITC** has been able to identify opportunities and implement interventions such as:
  - Face-to-Face Provider engagement program to educate providers on HEDIS Measures
  - Health Home Pay for Performance program
  - Behavioral Health Provider Pay for Performance incentive program.
  - Behavioral Health Case Management program
  - Increased ingestion of supplemental data from primary care providers and large health systems to increase care gap closure of measures not closed through claims.
  - Target non-compliant SSD members and offer in home diabetic kits. Inform providers that home test kits are available to members.
  - MTM Pharmacy texting program
  - Halo (Health Assisted Linkage and Outreach program)

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

PMV Results:

- Due to the PCSP being electronic, **ITC** has been able to eliminate some work for case managers. This includes no longer completing a word document version of the PCSP. Case managers had been documenting certain aspects of the PCSP meeting in case notes. **ITC** pulls those items directly from the PCSP now. **ITC** has also been able to begin eliminating other documentation that was used to gather the information that is already captured within the PCSP.
- **ITC** is continuing to work with Access2Care on ingestion of their data, so there are not currently any improvements to note.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

HEDIS Results:

- Women's Health:
  - The Breast Cancer Screening (BCS) measure for **Iowa Total Care** saw a 4.79 percentage point increase from 44.82% in 2021 to 49.61% in 2022.
  - PPC-TOPC rate for **Iowa Total Care** saw a 6.32 percentage point increase from 75.43% in 2021 to 81.75% in 2022.

- Behavioral Health-
  - Diabetes Monitoring for People With Diabetes and Schizophrenia (SSD) and Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing (APM)
    - **Iowa Total Care** has seen a steady increase with diabetic monitoring for people with diabetes and schizophrenia with 2020 rate of 73.54 and 2022 rate of 77.59. Currently for 2023 **ITC** is trending 2 percentage points higher than this time last year indicating our interventions are having a positive impact.
    - For APM, **ITC** has seen a steady raise year over year of 4% points 20.76% in 2020 to 24.76 in 2022. For 2023 we are trending about 1.50% points higher than same time last year indicating interventions are having positive impact.

c. Identify any barriers to implementing initiatives:

PMV Results:

- The PSCP was a very large assessment to build in TC. It took a lot of development resources to build the assessment and then create a fillable PDF that can be used in TCA. This required coordination between the health plan and corporate partners. The majority of this work is completed. However, **ITC** is still fine tuning the process.
- Early in the process there were issues with the data being collected from Access2Care not being accepted into our EDW. This delayed our efforts in obtaining the data and automating the reporting. Our corporate business partners at Centene started a project in early 2023 to collect external vendor encounter data. The project is on track to complete by the end of 2023. Access2Care was made aware of this corporate initiative recently and are working to provide all requested encounter data.

HEDIS Results:

- Currently all planned interventions for 2023 are on target for implementation.

HSAG Assessment: HSAG has determined that **Iowa Total Care** addressed the prior year's recommendations and made improvements in several performance measure rates, including a nearly 5 percentage-point increase in the *Breast Cancer Screening* measure rate and a 6 percentage-point increase in the *Prenatal and Postpartum Care* measure rate. The rate for the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure demonstrated a smaller rate increase of 3 percentage points, and the rate for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure only demonstrated a 1 percentage-point increase. Because both behavioral health measures remained below the 25th percentile, ongoing opportunities for improvement still remain. HSAG recommends that **Iowa Total Care** continue to focus on improvement strategies and targeted interventions for those measures that continued to show low performance.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: - HSAG did not identify any substantial weaknesses for **Iowa Total Care** as no program area scored at or below 80 percent compliance. Therefore, no recommendations were made.
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)***:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG Assessment: HSAG did not identify any substantial weaknesses for **Iowa Total Care** through the compliance review activity. Therefore, no recommendations were made, and this section is not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended the following: - Less than 1 percent of **Iowa Total Care** members did not have access to outpatient behavioral health providers within the time/distance standards. 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. 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.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: - **ITC** continues to monitor the Iowa Medicaid Provider File for new behavioral health providers that could be contracted with. Additionally, when an out of network provider submits claims, **ITC** works to enroll the provider with Iowa Medicaid and execute a contract with the provider. The network is monitored on a regular basis by **ITC** and Iowa Medicaid via the quarterly B10 report.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

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

c. Identify any barriers to implementing initiatives:

- The rates paid by Medicaid have been an issue in the past when attempting to contract with behavioral health providers. **ITC** is hopeful to hear fewer of those concerns because on July 1st of 2023, Medicaid rates were increased.

HSAG Assessment: HSAG has determined that **Iowa Total Care** addressed the prior year's recommendations by continually monitoring for new behavioral health providers and executing contracts with out-of-network providers when able. However, as the CY 2023 NAV activity methodology did not align with the 2022 activity, HSAG was unable to validate any performance improvement.

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

HSAG recommended the following:

Medical Record Review:

- **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. 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. **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).
- 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. 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. **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.

Comparative Analysis

- HSAG did not identify any substantial weaknesses for **Iowa Total Care** through the EDV activity. Therefore, no recommendations were made.

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

MCP's Response

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

- **ITC** has created a workgroup that is meeting to discuss a wholistic approach to addressing provider documentation issues. The workgroup includes members from Quality, Operations, Provider Network and Provider Relations departments. As part of this workgroup, **ITC** is evaluating contracts, communications, and oversight processes to ensure there is a thoughtful approach to outreach, education, and monitoring of providers.

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

- **ITC**'s work is ongoing and there are no improvements to note yet.

c. Identify any barriers to implementing initiatives:

- None currently.

HSAG Assessment: **Iowa Total Care**'s proactive approach in creating a multidisciplinary workgroup is commendable. The ongoing evaluation of contracts and processes reflects a commitment to addressing the root causes of the identified issues. As such, HSAG has determined that **Iowa Total Care** addressed the prior year's recommendations, as indicated by the action plans noted in the MCO's response. Of note, medical record review was not included as part of the CY 2023 EDV; therefore, performance improvement could not be assessed.

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

HSAG recommended the following:

- HSAG did not identify any CAHPS survey weaknesses for **Iowa Total Care**. Therefore, no recommendations were made.

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)***:

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

c. Identify any barriers to implementing initiatives:

HSAG Assessment: HSAG did not identify any substantial weaknesses for **Iowa Total Care** through the CAHPS survey activity. Therefore, no recommendations were made, and this section is not applicable

Molina Healthcare of Iowa, Inc.

Molina of Iowa was a new MCO in Iowa effective July 1, 2023; therefore, an assessment of the prior year's recommendations is not applicable.

6. Follow-Up on Prior EQR Recommendations for PAHPs

From the findings of each PAHP's performance for the CY 2023 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Iowa Managed Care Program. The recommendations provided to each PAHP for the EQR activities in the *Calendar Year 2022 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** 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. **Delta Dental** did not follow the HHS-defined performance indicator specifications in the design of the project. HSAG recommends that **Delta Dental** follow the HHS-defined specifications for collecting and reporting the performance indicator results.
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** reviewed and updated procedure codes and the denominator description for the DWP adult population to be in alignment with performance measures for SFY23 and HHS-defined specifications. These items were reviewed by the Quality Management and Improvement Committee.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • These initiatives will be implemented and reflected in **Delta Dental**'s future Performance Improvement Project submission for SFY23.
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Assessment: HSAG has determined that **Dental Delta** partially addressed the prior year's recommendations. The PAHP revised the performance indicator descriptions and corrected the requirement that the eligible population must have had a dental visit during the measurement period; however, the PAHP had opportunities to improve its documentation on the eligible population and the procedure codes used to capture the denominator.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

HSAG recommended the following:

- 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. **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. 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.

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** revised its process to no longer adjust claims manually. This revision was communicated through a newly implemented policy and procedure, and internal staff and provider training. The policy and procedure and training were approved by the Utilization Review Subcommittee of the Quality Management and Improvement Committee and discussed at the Clinical and Peer Review Committee. Internal staff are to follow-up directly with the applicable provider for any discrepancies noted in submitted claims.

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

- Since ending manual adjustment of claims, the process is more accurate and does not have negative downstream effects.

c. Identify any barriers to implementing initiatives:

- Not applicable.

HSAG Assessment: HSAG has determined that **Delta Dental** addressed the prior year's recommendations, denoting gains in the accuracy of adjusted claims and reduction in negative downstream impacts.

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

HSAG recommended the following:

- **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. **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. **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.
- **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

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

federal and State contractual provisions. 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. 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.

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** reviewed its credentialing forms and procedures and made the applicable revisions. The credentialing and recredentialing policies and procedural checklists were updated and approved by the Chief Dental Officer. An additional field was also added to the Credentialing Application Form to allow for provider explanations of any adverse responses. An internal tracking log, monitored by Professional Relations team, ensures a 36-month time frame for recredentialing. The Professional Relations Manager and Chief Dental Officer provide final review and oversight of credentialing and recredentialing applications.
- **Delta Dental** created and implemented a Subcontractor oversight program for all Government Program subcontractors. All program aspects were created and approved by **Delta Dental**'s Compliance and Government Programs teams. This program includes a documented process for effective oversight of subcontractor's delegated activities, including a delegated functions test, policies, procedures, quality assurance forms and Corrective Action Plan forms. All statements of work have been updated to be more descriptive of responsibilities.

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

- Regarding Subcontractors, we have seen an increase in overall organization to tracking each subcontractor and their delegated functions. Also, overall compliance with federal and State regulations.

c. Identify any barriers to implementing initiatives:

- Not applicable.

HSAG Assessment: HSAG has determined that **Delta Dental** addressed the prior year's recommendations. The CY 2023 compliance review activity confirmed that the PAHP successfully remediated all deficiencies within the Provider Selection and Subcontractual Relationships and Delegation standards.

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

HSAG recommended the following:

- HSAG did not identify any substantial weaknesses for **Delta Dental** through the NAV activity. Therefore, no recommendations were made.

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)***:

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

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

c. Identify any barriers to implementing initiatives:

HSAG Assessment: HSAG did not identify any substantial weaknesses for **Delta Dental** through the NAV activity. Therefore, no recommendations were made, and this section is not applicable.

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

HSAG recommended the following:

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

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 the State to determine how surfaces are loaded into the Medicaid Management Information System (MMIS). We updated our Encounter Data Validation processes to mirror how that data is converted and matched that logic.

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

  - The *Tooth Surface* information and Oral Cavity Code values match more accurately to HHS' MMIS.

c. Identify any barriers to implementing initiatives:

  - Not applicable.

HSAG Assessment: HSAG has determined that **Delta Dental** addressed the prior year's recommendations. **Delta Dental** has implemented initiatives to address the recommendation related to *Tooth Surface* information and Oral Cavity Code values. **Delta Dental** collaborated with the State to understand how surfaces are loaded into the MMIS and updated its EDV processes accordingly, resulting in improved accuracy and noted performance improvement.

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:

- HSAG did not identify any substantial weaknesses for **MCNA Dental** through the PIP activity. Therefore, no recommendations were made.

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)***:

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

c. Identify any barriers to implementing initiatives:

HSAG Assessment: HSAG did not identify any substantial weaknesses for **MCNA Dental** through the PIP activity. Therefore, no recommendations were made, and this section is not applicable.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

HSAG recommended the following:

- **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. **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. 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.

2. Prior Year Recommendation from the EQR Technical Report for Performance 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)***:

- **MCNA**'s initiatives have always been, and will always be, to promptly reach out to HHS regarding any PAHP Performance Measure technical specifications. Prior to HSAG drafting the recommendations this response is targeting, **MCNA** contended, with evidence, said initiative had always been the case. **MCNA** alerted DHHS in **January 2022** by email that the DHHS Reporting Template included some deleted CDT codes for preventive services provided to the Dental Wellness Plan (DWP) Kids population that had been replaced with updated codes by the American Dental Association (ADA) in 2019 and 2020. DHHS indicated to **MCNA** in response that the Reporting Template would be updated and recommended for **MCNA** to report DWP Kids measure data using the updated code list that **MCNA** had provided. **MCNA** wanted to include deleted codes in that this is the norm for quality measurement; 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 DHHS provided to HSAG for the 2022 PMV, the deleted codes were not included. HSAG did not send DHHS's template to **MCNA** until after the PMV itself on **July 21, 2022** – three days after the PMV on **July 18, 2022**. HSAG verbally told DHHS during PMV they did not know of the fact that DHHS was excluding the deleted codes in the 2022 performance measure rates. At HSAG's request, **MCNA** removed the services associated with the deleted codes from its Rate Reporting Template for the PMV activity and resubmitted the updated measure rates. The 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.

  In short, **MCNA** accepts HSAG recommendation that both **MCNA** and HSAG maintain prompt communication with one another regarding any PAHP Performance Measures Technical Specifications interpretation questions and verify proposed changes to the specifications as documented in the published DHHS Reporting Template and/or Technical Specifications document prior to submitting the Rate Reporting Template for annual performance measure validation.

  [screen shots redacted]

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

- The matter at hand cannot be quantitatively evaluated to assign a nominal performance improvement. **MCNA** does continue to pride itself on its attentiveness to details surrounding any and all reporting requirements from DHHS.

c. Identify any barriers to implementing initiatives:

- No barriers are identified.

HSAG Assessment: HSAG has determined that **MCNA Dental** addressed the prior year's recommendation and demonstrated efforts to maintain communication with both HSAG and HHS pertaining to any technical specification interpretation questions.

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

HSAG recommended the following:

- **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

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

delegates included all required federal and State contractual provisions. 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 sub-regulatory guidance and contract provisions. The delegation agreements also did not consistently include the required right to audit provisions. 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.

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 provided the feedback to Fiserv and the attached amendment has been approved and will be signed by 9/1/23. It clarifies that audits by the entities specified in the federal regulation do not require advanced notice by adding this clarifying language - (or, in the event of an Audit to be performed by Client's regulatory agency, CMS, the HHS Inspector General, the Comptroller General, or their designees, then at any time with no notice).

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

- Not applicable.

c. Identify any barriers to implementing initiatives:

- No barriers are identified.

HSAG Assessment: HSAG has determined that **MCNA Dental** addressed the prior year's recommendations. The CY 2023 compliance review activity confirmed that the PAHP successfully remediated all deficiencies within the Subcontractual Relationships and Delegation standard.

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

HSAG recommended the following:

- 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. 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. 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.

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 continues to recruit providers in areas identified as deficient due to the lack of providers that participate in Medicaid in remote areas of urban areas due to members living in the outskirts of these areas. The Network Development team reviews multiple resources to identify if dental providers have moved into this area, including NPI Registry, Board of Dental Examiners licensed listings, Dental Association listings and internet searches. The Network Development team also research for dental

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

providers in neighboring states to identify if providers are willing to participate in the state's Medicaid program.

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

- There has been little to no improvement due to barriers indicated below.

c. Identify any barriers to implementing initiatives:

- Providers that have been identified as potential candidates for participation refuse to participate in any government programs due to administrative burdens, missed appointments and low reimbursement fees. Providers will not negotiate fees and refuse to participate. These areas are also identified as provider shortage areas whereby there is a lack of providers and or lack of sufficient providers willing to participate in Medicaid.

HSAG Assessment: HSAG has determined that **MCNA Dental** addressed the prior year's recommendations. The PAHP reported various activities being performed to identify and recruit additional providers. However, **MCNA** has been unsuccessful due to a lack of available providers and/or a lack of providers willing to participate in the Medicaid program.

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

HSAG recommended the following:

- 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. It appears that **MCNA Dental** included the adjusted records that were not in the final status as HSAG had requested. 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.
- 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. **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. 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.

MCP's Response

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

- For both noted areas changes were made to the query used to pull the encounter data for the validation process:
    1. **MCNA** is no longer calculating the oral cavity - this will be provided only if the provider supplied the data as part of the claim.
    2. Changes were made to the report to only show the final status of the encounter.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
3. Change has been made to present on the encounter the data provided on the claim, even if the data is not required from a claim adjudication perspective.
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** addressed the prior year's recommendations. **MCNA Dental**, as noted through its responses, implemented initiatives to address the recommendations related to errors in data files and missing tooth information, and included changes to the query used to pull encounter data for the validation process.

7. Managed Care Plan Comparative Information

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

External Quality Review Activity Results

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

Validation of Performance Improvement Projects

For the CY 2023 validation, the MCOs submitted Remeasurement 2 data for the two HHS-mandated PIP topics, and the PAHPs submitted Remeasurement 1 data for the HHS-mandated PIP topics. HSAG's validation evaluated the technical methods of the MCPs' PIPs (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of each MCP's PIP and assigned an overall validation rating (i.e., *Met*, *Partially Met*, or *Not Met*).

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

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

MCP	Overall PIP Validation Ratings		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*	100%	0%	0%
ITC	*CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*	*Met*	100%	0%	0%
DDIA	*Annual Preventative Dental Visits*	*Partially Met*	84%	16%	0%
MCNA	*Increase the Percentage of Dental Services*	*Met*	100%	0%	0%

As the PIP topics, indicators, and stages varies between the MCOs and PAHPs, the baseline and Remeasurement rates were not included in Table 7-1. Instead, Table 7-2 presents each MCP's PIP topic, performance indicators, and a summary of the PIP outcomes (i.e., level of success) during each Remeasurement period, as applicable.

Table 7-2—Comparison of PIP Outcomes by MCP and Remeasurement Period

MCP	PIP Topic	Performance Indicator	PIP Outcome	
			R1	R2
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.	↑	↑
AGP	*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.	⇔	⇔
ITC	*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.	⇔	↓
DDIA	*Annual Preventative Dental Visits*	(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.	⇔	—
		(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.	↑	—
		(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*	The percentage of members 19 years of age and older who had at least one preventive dental visit during the measurement year.	↓	—
		The percentage of members 18 years of age and younger who had at least one preventive dental visit during the measurement year.	↑	—

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
— = MCP has not progressed to Remeasurement 2.

Performance Measure Validation

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

Table 7-3—Performance Measure Rates

Performance Measures		Measure Designation	Measure Rate
1.	*Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months–17 Years*	*R*	72.45%
2.	*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase*	*R*	56.98%
	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase		62.16%
3.	*Ambulatory Care: Emergency Department (ED) Visits—Total*	*R*	33.92
4.	*Antidepressant Medication Management—Effective Acute Phase Treatment—Ages 18–64 Years*	*R*	54.15%
	Antidepressant Medication Management—Effective Acute Phase Treatment—Ages 65 and Older		NA
	Antidepressant Medication Management—Effective Continuation Phase Treatment—Ages 18–64 Years		31.45%
	Antidepressant Medication Management—Effective Continuation Phase Treatment—Ages 65 and Older		NA
5.	*Asthma Medication Ratio—Ages 5–11 Years*	*R*	78.24%
	Asthma Medication Ratio—Ages 12–18 Years		65.77%
6.	*Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*	*R*	23.58%
7.	*Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*	*R*	62.22%
8.	*Screening for Depression and Follow-Up Plan—Ages 18–64 Years*	*R*	0.73%
	Screening for Depression and Follow-Up Plan—Ages 65 and Older		0.77%
9.	*Screening for Depression and Follow-Up Plan—Ages 12–17 Years*	*R*	1.42%
10.	*Chlamydia Screening in Women—Ages 16–20 Years*	*R*	36.72%
11.	*Childhood Immunization Status—Combination 3*	*R*	35.26%
	Childhood Immunization Status—Combination 7		30.80%
	Childhood Immunization Status—Combination 10		17.20%
12.	*Developmental Screening in the First Three Years of Life—Total*	*R*	34.00%

Performance Measures		Measure Designation	Measure Rate
13.	*Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Ages 13–17 Years*	*R*	54.03%
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Ages 13–17 Years		62.10%
14.	*Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Ages 18–64 Years*	*R*	57.25%
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Ages 18–64 Years		66.26%
	Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Ages 65 and Older		NA
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Ages 65 and Older		NA
15.	*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6–17 Years*	*R*	54.47%
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6–17 Years		75.02%
16.	*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18–64 Years*	*R*	41.22%
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18–64 Years		61.51%
	Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 and Older		NA
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65 and Older		NA
17.	*Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 6–17 Years*	*R*	50.56%
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Ages 6–17 Years		73.96%
18.	*Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 18–64 Years*	*R*	34.69%
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Ages 18–64 Years		52.08%
	Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 65 and Older		NA
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Ages 65 and Older		NA
19.	*Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)—Ages 18–64 Years*	*R*	91.73%
	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)—Ages 65–75 Years		NA
20.	*Initiation and Engagement of Substance Use Disorder Treatment—Initiation—Total*	*R*	39.20%
	Initiation and Engagement of Substance Use Disorder Treatment—Engagement—Total		15.45%

Performance Measures		Measure Designation	Measure Rate
21.	*Immunizations for Adolescents—Combination 1*	R	60.93%
	Immunizations for Adolescents—Combination 2		20.25%
22.	*Lead Screening in Children*	R	67.95%
23.	*Use of Pharmacotherapy for Opioid Use Disorder—Total*	R	61.42%
24.	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia*	R	73.26%
25.	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	R	75.63%
26.	*Well-Child Visits in the First 30 Months—Well-Child Visits in the First 15 Months*	R	60.11%
	Well-Child Visits in the First 30 Months—Well-Child Visits for Age 15 Months–30 Months		64.08%
27.	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile*	R	23.01%
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition		9.99%
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity		7.17%
28.	*Child and Adolescent Well-Care Visits—Total*	R	55.77%

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

Table 7-4 displays the HEDIS MY 2022 rates for the MCOs and the statewide weighted averages.

Table 7-4—SFY 2023 (MY 2022) HEDIS Rates—MCO Comparison

HEDIS Measures	Amerigroup HEDIS MY 2022 Rate	Iowa Total Care HEDIS MY 2022 Rate	Statewide HEDIS MY 2022 Weighted Averages
Access to Preventive Care			
Adults' Access to Preventive/Ambulatory Health Services			
20–44 Years	77.91% ★★★	77.46% ★★★	77.72% ★★★
45–64 Years	84.36% ★★★	83.91% ★★★	84.16% ★★★
65 Years and Older	91.71% ★★★★	84.62% ★★★	86.84% ★★★
Use of Imaging Studies for Low Back Pain			
Use of Imaging Studies for Low Back Pain	69.97% NC	68.75% NC	69.47% NC

HEDIS Measures	Amerigroup HEDIS MY 2022 Rate	Iowa Total Care HEDIS MY 2022 Rate	Statewide HEDIS MY 2022 Weighted Averages
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	81.19% ★★★	70.07% ★	77.33% ★★
Counseling for Nutrition—Total	69.59% ★★	58.39% ★	65.70% ★★
Counseling for Physical Activity—Total	66.75% ★★	54.01% ★	62.33% ★★
Women's Health			
Breast Cancer Screening			
Breast Cancer Screening	53.32% ★★★	49.61% ★★	51.68% ★★★
Cervical Cancer Screening			
Cervical Cancer Screening	61.56% ★★★	56.69% ★★	59.52% ★★★
Chlamydia Screening in Women			
Total	46.68% ★	47.89% ★	47.15% ★
*Non-Recommended Cervical Cancer Screening in Adolescent Females**			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.18% ★★★★	0.48% ★★★	0.29% ★★★
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	89.51% ★★★★	81.75% ★★	86.13% ★★★
Postpartum Care	82.62% ★★★★	77.86% ★★★	80.55% ★★★
Living With Illness			
Hemoglobin A1c Control for Patients With Diabetes			
HbA1c Control (<8%)	62.29% ★★★★★	48.42% ★★	56.19% ★★★★
*HbA1c Poor Control (>9.0%)**	27.49% ★★★★★	41.61% ★★	33.70% ★★★★
Blood Pressure Control for Patients With Diabetes			
Blood Pressure Control (<140/90 mm Hg)	77.86% ★★★★★	69.10% ★★★★	74.01% ★★★★★
Eye Exam for Patients With Diabetes			
Eye Exam (Retinal) Performed	59.37% ★★★★	56.69% ★★★★	58.19% ★★★★

HEDIS Measures	Amerigroup HEDIS MY 2022 Rate	Iowa Total Care HEDIS MY 2022 Rate	Statewide HEDIS MY 2022 Weighted Averages
Controlling High Blood Pressure			
Controlling High Blood Pressure	68.13% ★★★★	61.07% ★★★	65.04% ★★★
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	81.24% ★★★	69.03% ★	75.72% ★
Statin Therapy for Patients With Diabetes			
Received Statin Therapy	65.21% ★★	56.09% ★	61.17% ★
Behavioral Health			
Diabetes Monitoring for People With Diabetes and Schizophrenia			
Diabetes Monitoring for People With Diabetes and Schizophrenia	72.16% ★★★	58.06% ★	65.89% ★★
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	78.08% ★★	77.59% ★★	77.88% ★★
Follow-Up After Emergency Department Visit for Substance Use			
7-Day Follow-Up—Total	59.35% NC	56.74% NC	58.14% NC
30-Day Follow-Up—Total	69.09% NC	66.30% NC	67.79% NC
Follow-Up After ED Visit for Mental Illness			
7-Day Follow-Up—Total	65.45% ★★★★★	63.69% ★★★★★	64.74% ★★★★★
30-Day Follow-Up—Total	76.06% ★★★★★	75.03% ★★★★★	75.64% ★★★★★
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up—Total	63.54% ★★★★★	52.84% ★★★★	59.15% ★★★★★
30-Day Follow-Up—Total	79.03% ★★★★★	71.37% ★★★★	75.89% ★★★★★
Initiation and Engagement of Substance Use Disorder Treatment			
Initiation of AOD Treatment—Total	65.28% NC	58.37% NC	62.25% NC
Engagement of AOD Treatment—Total	24.17% NC	20.94% NC	22.75% NC

HEDIS Measures	Amerigroup HEDIS MY 2022 Rate	Iowa Total Care HEDIS MY 2022 Rate	Statewide HEDIS MY 2022 Weighted Averages
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose and Cholesterol Testing—Total	26.29% ★	24.76% ★	25.79% ★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
Total	62.92% ★★★	61.74% ★★	62.51% ★★★
Keeping Kids Healthy			
Childhood Immunization Status			
Combination 3	71.78% ★★★★	74.94% ★★★★★	73.19% ★★★★
Combination 10	42.09% ★★★★	45.50% ★★★★	43.61% ★★★★
Immunizations for Adolescents			
Combination 1	83.94% ★★★	84.43% ★★★	84.12% ★★★
Combination 2	35.77% ★★★	34.31% ★★	35.24% ★★★
Lead Screening in Children			
Lead Screening in Children	73.72% ★★★★	74.93% ★★★★	74.26% ★★★★
Well-Child Visits in the First 30 Months of Life			
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	62.75% ★★★★	66.01% ★★★★	64.19% ★★★★
Well-Child Visits for Age 15 Months-30 Months—Two or More Well-Child Visits	68.46% ★★★	70.70% ★★★	69.41% ★★★
Child and Adolescent Well-Care Visits			
Total	49.65% ★★★	50.54% ★★★	49.98% ★★★
Medication Management			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.78% ★★★	59.99% ★★	62.74% ★★★
Antidepressant Medication Management			
Effective Acute Phase Treatment	62.38% ★★★	60.82% ★★★	61.75% ★★★
Effective Continuation Phase Treatment	44.24% ★★★	42.60% ★★	43.57% ★★★

HEDIS Measures	Amerigroup HEDIS MY 2022 Rate	Iowa Total Care HEDIS MY 2022 Rate	Statewide HEDIS MY 2022 Weighted Averages
Appropriate Testing for Pharyngitis			
Total	80.61% ★★★★★	80.05% ★★★★★	80.40% ★★★★★
Appropriate Treatment for Upper Respiratory Infection			
Total	89.71% ★★	89.90% ★★	89.79% ★★
Asthma Medication Ratio			
Total	67.36% ★★★	65.87% ★★★	66.82% ★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis			
Total	56.12% ★★★	59.55% ★★★	57.51% ★★★
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	49.29% ★★★★	52.88% ★★★★★	50.58% ★★★★★
Continuation and Maintenance Phase	53.55% ★★★	57.90% ★★★★	55.10% ★★★
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	83.68% ★★★	75.14% ★	79.61% ★★
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	75.21% ★★★	69.01% ★★	72.29% ★★★
Bronchodilator	79.66% ★	74.97% ★	77.45% ★
Statin Therapy for Patients With Cardiovascular Disease			
Statin Adherence 80%—Total	71.71% ★★★	68.79% ★★	70.51% ★★★
Statin Therapy for Patients With Diabetes			
Statin Adherence 80%—Total	69.92% ★★★	67.79% ★★★	69.06% ★★★
*Use of Opioids at High Dosage**			
Use of Opioids at High Dosage	2.34% ★★★	1.88% ★★★★	2.14% ★★★
*Use of Opioids From Multiple Providers**			
Multiple Prescribers	17.09% ★★★	17.07% ★★★	17.08% ★★★

HEDIS Measures	Amerigroup HEDIS MY 2022 Rate	Iowa Total Care HEDIS MY 2022 Rate	Statewide HEDIS MY 2022 Weighted Averages
Multiple Pharmacies	1.24% ★★★★	1.63% ★★★	1.41% ★★★
Multiple Prescribers and Multiple Pharmacies	0.88% ★★★	1.16% ★★★	1.00% ★★★

* For this indicator, a lower rate indicates better performance.
"NC" indicates that NCQA recommended a break in trending; therefore, the rate could not be compared to the national Medicaid MY 2021 benchmarks.
HEDIS MY 2022 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 7-5 displays the DWP Adult rates for each PAHP and the statewide aggregate rate, and Table 7-6 displays the DWP Kids rates for each PAHPs and the statewide aggregate rate. No rate comparison is provided for the Hawki population since **Delta Dental** is the only PAHP that oversees this member population.

Table 7-5—SFY 2023 Performance Measure Rates for DWP Adults—PAHP Comparison

Performance Measure		Measure Rates – DWP Adults		
		DDIA	MCNA	Statewide Aggregate
2	*Members Who Accessed Dental Care*	29.02%	16.00%	24.11%
3	*Members Who Received Preventive Dental Care*	75.21%	60.66%	71.57%
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])*	60.64%	41.54%	56.64%

*Performance measure #6 includes three distinct components.

Table 7-6—SFY 2023 Performance Measure Rates for DWP Kids—PAHP Comparison

	Performance Measure	Measure Rates – DWP Kids		
		DDIA	MCNA	Statewide Aggregate
3	*Members Who Received Preventive Dental Care*	51.15%	38.33%	46.28%
7	*Providers Seeing Patients*	84.67%	63.78%	83.78%*

*The numerator and denominator criteria for the statewide aggregate were analyzed at the statewide level to account for potential duplication of providers contracted across **DDIA** and **MCNA**, which creates the potential for the aggregate rate to approximate or increase above the higher MCO-reported rate.

Compliance Review

HSAG calculated 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 7-7 compares the MCPs' compliance scores and the Iowa Managed Care Program aggregated score in each of the 14 compliance review standards.

Table 7-7—MCP and Iowa Managed Care Program Compliance Review Scores for the Three-Year Cycle (CY 2021–2023)

Standard[1]	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 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%**
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[1]	AGP	ITC	DDIA	MCNA	Iowa Managed Care Program
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[2]	100%	100%	85%	100%	**95%**
Standard XIV—Quality Assessment and Performance Improvement Program	93%	97%	88%	100%	**95%**
Combined Total	**90%**	**93%**	**85%**	**95%**	**91%**

[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 standard 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.

Table 7-8 compares the number of CAP elements and the *Complete* and *Not Complete* elements across the MCPs and the Iowa Managed Care Program for the CY 2023 CAP implementation review.

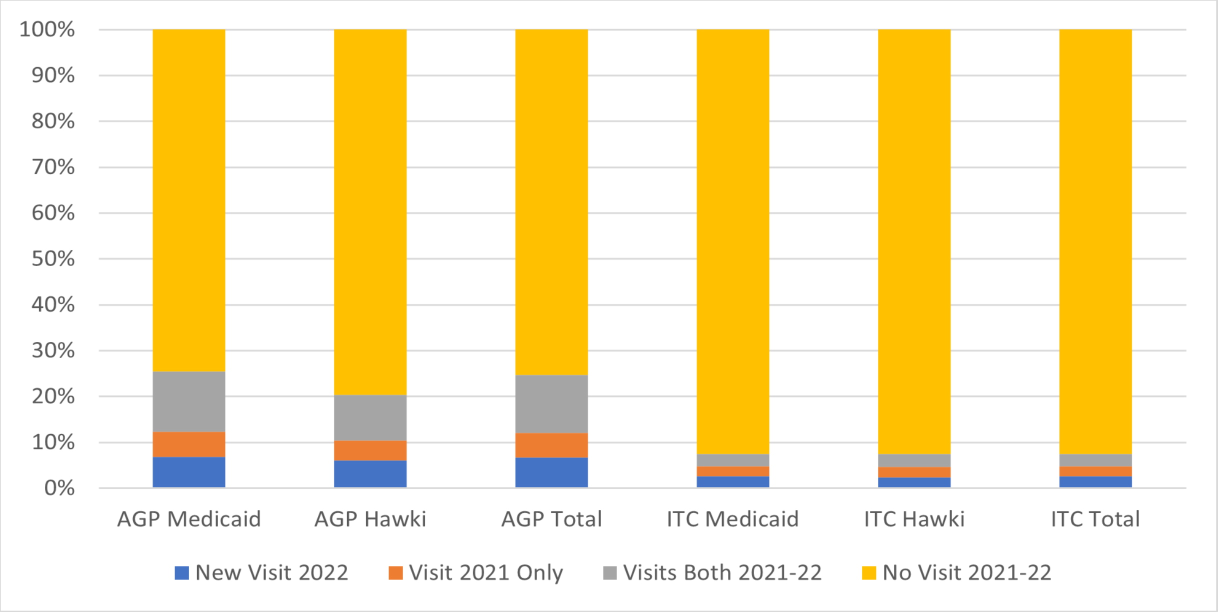
Table 7-8—MCP and Iowa Managed Care Program Summary of 2023 CAP Implementation

MCP	Total CAP Elements	Number of CAP Elements Complete	Number of CAP Elements Not Complete
AGP	20	16	4
ITC	14	13	1
DDIA	22	20	2
MCNA	7	6	1
Iowa Managed Care Program Total	**63**	**55**	**8**

Network Adequacy Validation

Figure 7-1 displays the percentage of pediatric members with behavioral health visits in 2021 and 2022 for **Amerigroup** and **Iowa Total Care** across Medicaid, Hawki, and overall for each MCO.

Figure 7-1—Percentage of Pediatric Members With Behavioral Health Visits in 2021 and 2022



Note: Pediatric members are ages 18 years and under with continuous enrollment in Medicaid and/or Hawki in 2021 and 2022. Behavioral health visits are defined as visits with a behavioral health provider. A new visit is defined as a visit with any behavioral health provider in 2022 for members who had no behavioral health visits in 2021.

Table 7-9 shows the percentage of pediatric members with new behavioral health visits, by MCO and MCO/LOB.

Table 7-9—Percentage of Pediatric Members With New Behavioral Health Visits

MCO and LOB	Number With New Visits	Number (Percent) With Inpatient New Visits	Number (Percent) With Outpatient New Visits	Number (Percent) With Inpatient and Outpatient New Visits*
Amerigroup				
Medicaid	10,277	4,433 (43.1%)	5,465 (53.2%)	379 (3.7%)
Hawki	1,665	759 (45.6%)	853 (51.2%)	53 (3.2%)
Total	11,942	5,192 (43.5%)	6,318 (52.9%)	432 (3.6%)
Iowa Total Care				
Medicaid	2,674	50 (1.9%)	2,618 (97.9%)	6 (0.2%)
Hawki	288	1 (0.3%)	287 (99.7%)	0 (0.0%)
Total	2,962	51 (1.7%)	2,905 (98.1%)	6 (0.2%)

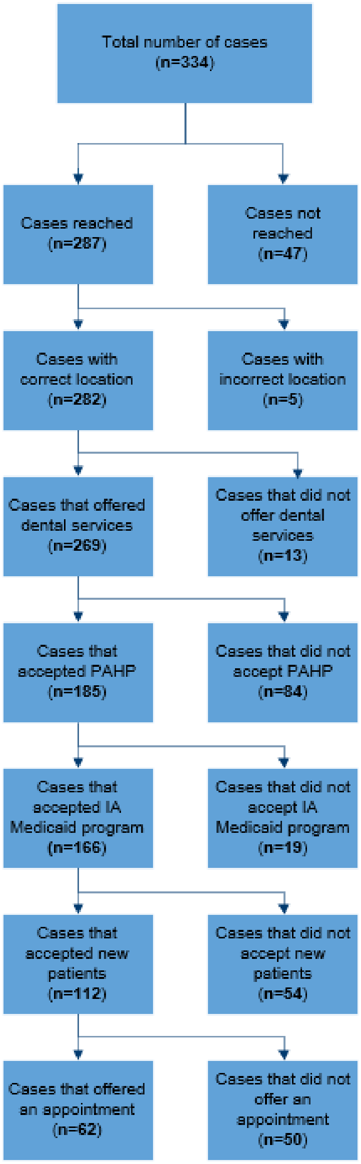
* The initial behavioral health visit in 2022 for these members was associated with a combination of inpatient and outpatient providers.

Note: Pediatric members are ages 18 years and under with continuous enrollment in Medicaid and/or Hawki in 2021 and 2022. Behavioral health visits are defined as visits with a behavioral health provider. A new visit is defined as a visit with any behavioral health provider in 2022 for members that had no behavioral health visits in 2021.

Secret Shopper Survey

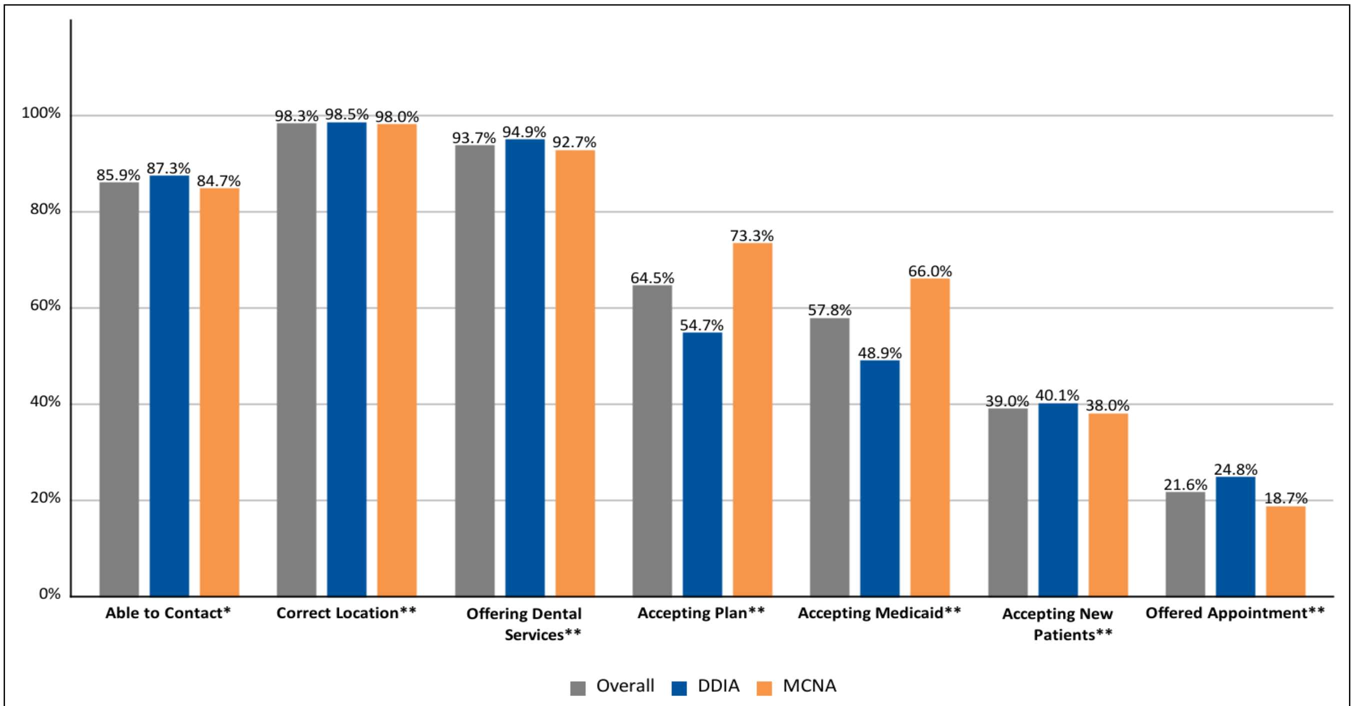
During September and October 2023, HSAG completed a secret shopper telephone survey of dental provider offices contracted with the PAHPs to serve individuals enrolled in Medicaid under the DWP Adults, DWP Kids, and Hawki programs. Figure 7-2 illustrates the flow of data collection during the survey calls, as well as the total number of cases with each potential survey outcome.

Figure 7-2—Secret Shopper Survey Data Collection Hierarchy and Count of Cases With Each Outcome


Total number of cases (n=334)
Cases reached (n=287)
Cases not reached (n=47)
Cases with correct location (n=282)
Cases with incorrect location (n=5)
Cases that offered dental services (n=269)
Cases that did not offer dental services (n=13)
Cases that accepted PAHP (n=185)
Cases that did not accept PAHP (n=84)
Cases that accepted IA Medicaid program (n=166)
Cases that did not accept IA Medicaid program (n=19)
Cases that accepted new patients (n=112)
Cases that did not accept new patients (n=54)
Cases that offered an appointment (n=62)
Cases that did not offer an appointment (n=50)

Overall, 85.9 percent of cases were able to be contacted. A case was considered contacted if the caller reached a live representative for a dental office. Among the cases contacted, 64.5 percent accepted the plan, 57.8 percent confirmed the location accepted Iowa Medicaid, and 39.0 percent accepted new patients. Of the cases contacted and accepting the plan and Medicaid, 21.6 percent offered an appointment. Figure 7-3 displays the telephone survey call outcomes.

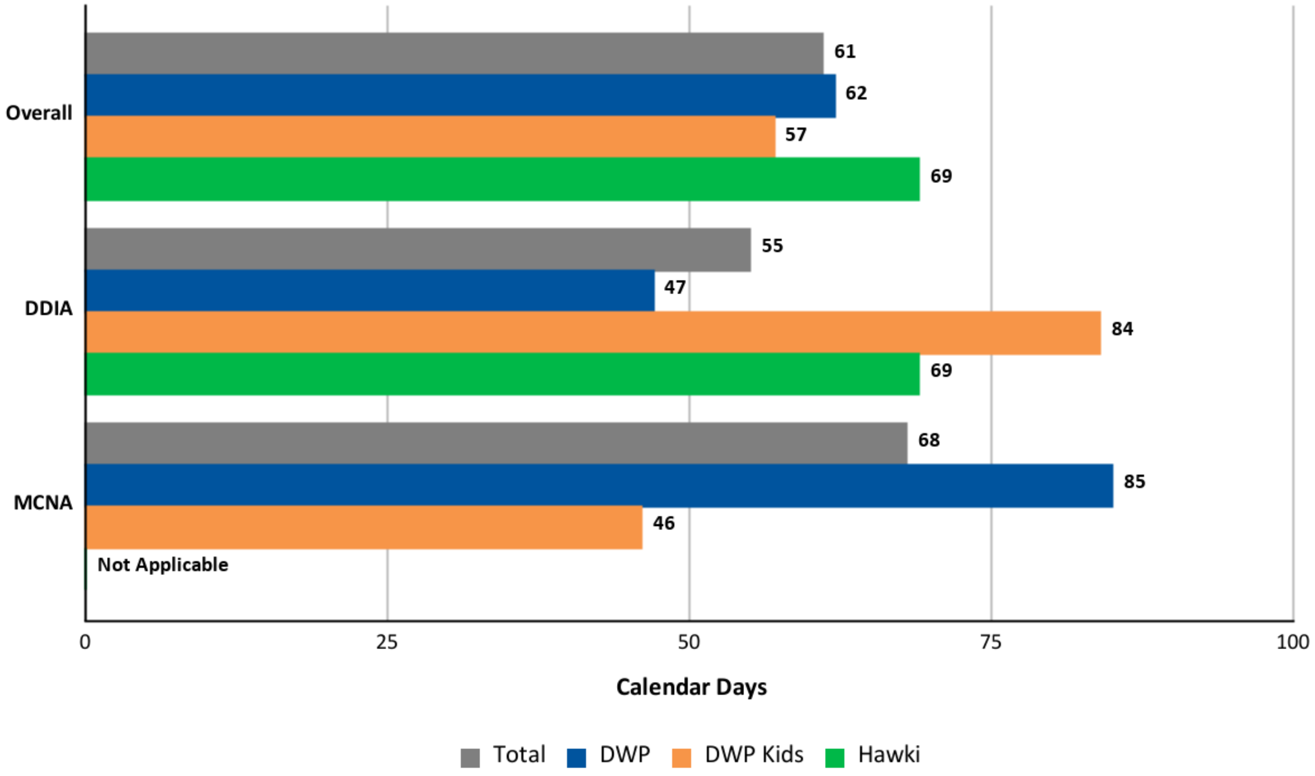
Figure 7-3—Summary of Secret Shopper Survey Case Outcomes, by PAHP



* The denominator includes all sampled providers.
** The denominator includes cases reached.

Figure 7-4 displays the average wait time, in calendar days, to schedule an appointment for a teeth cleaning. Appointments may have been offered with any practitioner at the sampled location.

Figure 7-4—New Patient Appointment Wait Time in Calendar Days for Routine Dental Services, by PAHP[7-1]



Encounter Data Validation

Targeted Comparative Analysis—MCO[7-2]

Table 7-10 displays the percentage of records present in the files submitted by the MCOs 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 the MCOs (record surplus). Lower rates indicate better performance for both record omission and record surplus.

[7-1] **MCNA Dental** does not serve the Hawki population; therefore, average wait times are not available for this population for **MCNA Dental**.

[7-2] **Molina of Iowa** began administering benefits and providing services to Iowa Medicaid managed care members on July 1, 2023. Since it was the first year of submitting encounter data to HHS, there was an insufficient amount of data to assess **Molina of Iowa**'s encounter data accuracy and completeness through this activity. Therefore, **Molina of Iowa** was not included in this EDV component of the activity. However, HSAG conducted an IS review activity to examine the extent to which **Molina of Iowa**'s IS infrastructure is likely to collect and process complete and accurate encounter data.

Table 7-10—Record Omission and Surplus Rates, by MCO and Encounter Type

MCO	Professional Encounters		Institutional Encounters	
	Omission	Surplus	Omission	Surplus
Amerigroup	2.3%	1.5%	1.5%	0.1%
Iowa Total Care	6.7%	5.0%	5.2%	<0.1%
Overall	4.2%	2.9%	3.1%	0.1%

Table 7-11 displays the element omission, element surplus, and element missing values 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 missing values indicator, lower or higher rates do not indicate better or worse performance.

Table 7-11—Data Element Omission, Surplus, and Missing Values: Professional Encounters

Key Data Element	Element Omission[1]			Element Surplus[2]			Element Missing Values[3]		
	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%	**<0.1%**	0.0%	<0.1%	**0.0%**	0.0%	0.0%
Billing Provider ZIP Code	**0.1%**	<0.1%	0.3%	**<0.1%**	0.0%	0.1%	**<0.1%**	0.0%	<0.1%
Billing Provider Taxonomy Code	**<0.1%**	0.0%	<0.1%	**<0.1%**	0.0%	<0.1%	**23.4%**	21.4%	26.3%
Rendering Provider NPI	**0.0%**	0.0%	0.0%	**16.3%**	0.0%	40.4%	**0.0%**	0.0%	0.0%
Referring Provider NPI	**0.7%**	0.0%	1.6%	**1.1%**	1.9%	0.0%	**57.6%**	59.0%	55.5%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Procedure Code[4] (CDT, CPT, HCPCS)	**0.0%**	0.0%	0.0%	**<0.1%**	0.0%	<0.1%	**0.0%**	0.0%	0.0%
Procedure Code Modifier[5]	**<0.1%**	0.0%	<0.1%	**<0.1%**	0.0%	<0.1%	**55.1%**	54.4%	56.2%
Units of Service	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%

[1] Element Omission displays the percentage of records with values present in the MCOs' submitted files but not in HHS' submitted files.
[2] Element Surplus displays the percentage of records with values present in HHS' submitted files but not in the MCOs' submitted files.
[3] Element Missing Values displays the percentage of records with values missing from both HHS' submitted files and MCOs' submitted files.
[4] Current Dental Terminology [CDT], Current Procedural Terminology [CPT], or Healthcare Common Procedure Coding System [HCPCS] code.
[5] Only the first procedure code modifier was assessed for the comparative analysis.

Table 7-12 displays the element omission, element surplus, and element missing values results for each key data element from the institutional encounters. **For the element omission and surplus indicators, lower rates indicate better performance.** However, for the element missing values indicator, lower or higher rates do not indicate better or worse performance.

Table 7-12—Data Element Omission, Surplus, and Missing Values: Institutional Encounters

Key Data Element	Element Omission[1]			Element Surplus[2]			Element Missing Values[3]		
	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%
Billing Provider NPI	**0.0%**	0.0%	0.0%	**<0.1%**	0.0%	<0.1%	**0.0%**	0.0%	0.0%
Billing Provider ZIP Code	**0.1%**	<0.1%	0.3%	**<0.1%**	0.0%	<0.1%	**<0.1%**	0.0%	<0.1%
Billing Provider Taxonomy Code	**0.9%**	0.0%	2.2%	**<0.1%**	0.0%	<0.1%	**1.4%**	2.5%	<0.1%
Attending Provider NPI	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.2%**	<0.1%	0.4%
Referring Provider NPI	**<0.1%**	0.0%	0.1%	**<0.1%**	0.0%	<0.1%	**96.5%**	96.6%	96.3%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Procedure Code[4] (CDT, CPT, HCPCS)	**0.1%**	0.1%	0.1%	**0.1%**	0.0%	0.2%	**15.2%**	14.8%	15.7%
Procedure Code Modifier[5]	**0.2%**	0.0%	0.4%	**0.2%**	0.0%	0.5%	**75.4%**	75.3%	75.6%
Units of Service	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Surgical Procedure Codes[6]	**<0.1%**	0.0%	<0.1%	**0.9%**	1.6%	0.0%	**95.0%**	95.4%	94.5%

[1] Element Omission displays the percentage of records with values present in the MCOs' submitted files but not in HHS' submitted files.

[2] Element Surplus displays the percentage of records with values present in HHS' submitted files but not in the MCOs' submitted files.

[3] Element Missing Values displays the percentage of records with values missing from both HHS' submitted files and MCOs' submitted files.

[4] Current Dental Terminology [CDT], Current Procedural Terminology [CPT], or Healthcare Common Procedure Coding System [HCPCS] code.

[5] Only the first procedure code modifier was assessed for the comparative analysis.

[6] All submitted surgical procedure codes were ordered and concatenated as a single data element for the comparative analysis.

Table 7-13 displays the percentage of records with the same values in the MCO-submitted files and the HHS-submitted files for each key data element associated with the professional encounters. **For this indicator, higher rates indicate better performance.**

Table 7-13—Data Element Accuracy: Professional Encounters

Key Data Element	Element Accuracy[1]		
	Overall	AGP	ITC
Member ID	**100.0%**	100.0%	100.0%
Detail Service From Date	**>99.9%**	100.0%	>99.9%
Detail Service To Date	**>99.9%**	100.0%	>99.9%
Billing Provider NPI	**99.9%**	100.0%	99.8%
Billing Provider ZIP Code	**69.7%**	70.4%	68.6%
Billing Provider Taxonomy Code	**>99.9%**	100.0%	99.9%
Rendering Provider NPI	**99.8%**	99.8%	>99.9%
Referring Provider NPI	**>99.9%**	100.0%	>99.9%
Primary Diagnosis Code	**100.0%**	100.0%	100.0%
Procedure Code[2] (CDT, CPT, HCPCS)	**>99.9%**	100.0%	>99.9%
Procedure Code Modifier[3]	**>99.9%**	100.0%	>99.9%
Units of Service	**99.9%**	>99.9%	99.7%

[1] Element Accuracy displays the percentage of records with the values present and having identical values in both MCOs' submitted files and HHS' submitted files.

[2] Current Dental Terminology [CDT], Current Procedural Terminology [CPT], or Healthcare Common Procedure Coding System [HCPCS] code.

[3] Only the first procedure code modifier was assessed for the comparative analysis.

Table 7-14 displays the percentage of records with the same values in the MCO-submitted files and the HHS-submitted files for each key data element associated with the institutional encounters. **For this indicator, higher rates indicate better performance.**

Table 7-14—Data Element Accuracy: Institutional Encounters

Key Data Element	Element Accuracy[1]		
	Overall	AGP	ITC
Member ID	**100.0%**	100.0%	100.0%
Header Service From Date	**>99.9%**	100.0%	>99.9%
Header Service To Date	**>99.9%**	100.0%	>99.9%
Billing Provider NPI	**>99.9%**	100.0%	>99.9%
Billing Provider ZIP Code	**95.1%**	95.0%	95.1%
Billing Provider Taxonomy Code	**95.9%**	100.0%	90.2%

Key Data Element	Element Accuracy[1]		
	Overall	AGP	ITC
Attending Provider NPI	**100.0%**	100.0%	100.0%
Referring Provider NPI	**100.0%**	100.0%	100.0%
Primary Diagnosis Code	**97.7%**	96.0%	100.0%
Procedure Code[2] (CDT CPT, HCPCS)	**98.8%**	100.0%	97.2%
Procedure Code Modifier[3]	**99.8%**	100.0%	99.5%
Units of Service	**98.1%**	100.0%	95.4%
Surgical Procedure Codes[4]	**47.6%**	0.0%	84.2%

[1] Element Accuracy displays the percentage of records with the values present and having identical values in both MCOs' submitted files and HHS' submitted files.

[2] Current Dental Terminology [CDT], Current Procedural Terminology [CPT], or Healthcare Common Procedure Coding System [HCPCS] code.

[3] Only the first procedure code modifier was assessed for the comparative analysis.

[4] All submitted surgical procedure codes were ordered and concatenated as a single data element for the comparative analysis.

Table 7-15 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 7-15—All Element Accuracy, by MCO and Encounter Type

MCO	Professional Encounters	Institutional Encounters
Amerigroup	68.4%	13.7%
Iowa Total Care	29.0%	26.2%
Overall	52.5%	19.0%

Note: The denominator for the all-element accuracy rate is defined differently from the denominators for the individual element accuracy rates since it includes data elements even if values are missing in both sources. If any of the data elements are an element omission, element surplus, or an inaccurate value match, the record will not be a positive hit for the all-element accuracy numerator.

Table 7-16 displays the percentage of legacy provider numbers in HHS' data that were not populated.

Table 7-16—Legacy Billing Provider Numbers Not Populated

MCO	Professional			Institutional		
	Total Number of Records	Legacy Provider Number Not Populated	Rate	Total Number of Records	Legacy Provider Number Not Populated	Rate
Amerigroup	13,870,624	728	<0.1%	8,429,344	2,467	<0.1%
Iowa Total Care	9,728,278	27,569	0.3%	6,110,014	16,450	0.3%

MCO	Professional			Institutional		
	Total Number of Records	Legacy Provider Number Not Populated	Rate	Total Number of Records	Legacy Provider Number Not Populated	Rate
Overall	23,598,902	28,297	0.1%	14,539,358	18,917	0.1%

Table 7-17 displays the percentage of legacy billing provider numbers in HHS' data that were populated for professional encounters, but key provider information did not match between HHS' and the MCOs' data sources. The rate was calculated only when the values were present in both data sources. If at least one of the values was missing in either data source, then they were not included in the denominator.

Table 7-17—Legacy Billing Provider Number Populated: Professional Encounters

MCO	ZIP Codes Did Not Match			Taxonomy Did Not Match		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Amerigroup	13,667,041	4,046,493	29.6%	10,739,683	0	0.0%
Iowa Total Care	9,204,647	2,888,631	31.4%	6,793,508	4,137	0.1%
Overall	22,871,688	6,935,124	30.3%	17,533,191	4,137	< 0.1%

Table 7-18 illustrates the percentage of legacy billing provider numbers in HHS' data that were populated for professional encounters, with HSAG confirming the provider type by place of service (POS), CPT, or both. The process to verify whether the provider type (derived from the legacy billing provider number) aligns with the services rendered on the claims data involved the following steps:

- Using the legacy billing provider number populated in the HHS-submitted encounter data, HSAG extracted the associated provider type from the HHS-submitted provider data.
- HSAG evaluated the assignment of these provider types, considering data elements from the encounter data such as POS, CPT codes, type of bill (TOB), and revenue codes.
- Data elements were grouped, and a subjective verification was conducted to ensure alignment with the assigned provider type.

Table 7-18—Legacy Billing Provider Type Validation by POS and CPT: Professional Encounters

MCO	Provider Type Matched Services on Claim on POS Only		Provider Type Matched Services on Claim on CPT Only		Provider Type Matched Services on Claim on Both POS and CPT	
	N	Rate	N	Rate	N	Rate
Amerigroup	13,670,145	98.6%	13,773,543	99.3%	13,609,567	98.1%
Iowa Total Care	9,569,648	98.6%	9,640,239	99.4%	9,526,763	98.2%
Overall	23,239,793	98.6%	23,413,782	99.3%	23,136,330	98.2%

Table 7-19 illustrates the percentage of legacy billing provider numbers in HHS' data that were populated for institutional encounters, but key provider information did not match between HHS' and the MCOs' data sources. The rate was calculated only when the values were present in both data sources. If at least one of the values was missing in either data source, then they were not included in the denominator.

Table 7-19—Legacy Billing Provider Number Populated: Institutional Encounters

MCO	ZIP Codes Did Not Match			Taxonomy Did Not Match		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Amerigroup	8,419,598	418,362	5.0%	8,210,353	0	0.0%
Iowa Total Care	6,093,087	298,817	4.9%	5,959,212	585,353	9.8%
Overall	14,512,685	717,179	4.9%	14,169,565	585,353	4.1%

Comparative Analysis—PAHP

Table 7-20 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 7-20—Dental Record Omission and Surplus Rates: By PAHP

	Record Omission			Record Surplus		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
DDIA	1,924,428	33,294	1.7%	1,900,368	9,234	0.5%
MCNA	706,797	100,867	14.3%	644,161	38,231	5.9%
Overall	2,631,225	134,161	5.1%	2,544,529	47,465	1.9%

Table 7-21 displays the element omission, element surplus, and element missing values 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 missing values indicator, neither lower nor higher rates indicate better or worse performance.

Table 7-21—Data Element Omission, Surplus, and Missing Values: By PAHP

Key Data Element	Element Omission[1]			Element Surplus[2]			Element Missing Values[3]		
	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%

Key Data Element	Element Omission[1]			Element Surplus[2]			Element Missing Values[3]		
	Overall Rate	DDIA	MCNA	Overall Rate	DDIA	MCNA	Overall Rate	DDIA	MCNA
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%
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	**0.5%**	<0.1%	1.8%	**0.1%**	<0.1%	0.4%	**75.1%**	76.1%	71.9%
Tooth Surface 1-5[4]	**7.2%**	9.2%	0.8%	**<0.1%**	0.0%	0.1%	**90.5%**	90.8%	89.9%
Tooth Surface 1	**7.2%**	9.2%	0.8%	**<0.1%**	0.0%	0.1%	**90.5%**	90.8%	89.9%
Tooth Surface 2	**4.5%**	5.9%	0.3%	**<0.1%**	0.0%	0.1%	**94.3%**	94.1%	94.7%
Tooth Surface 3	**1.4%**	1.9%	0.1%	**<0.1%**	0.0%	<0.1%	**98.1%**	98.1%	98.2%
Tooth Surface 4	**0.4%**	0.5%	<0.1%	**<0.1%**	0.0%	<0.1%	**99.5%**	99.5%	99.5%
Tooth Surface 5	**0.1%**	0.1%	<0.1%	**<0.1%**	0.0%	<0.1%	**99.9%**	99.9%	99.9%
Oral Cavity Code 1-5[5]	**<0.1%**	<0.1%	0.1%	**<0.1%**	<0.1%	<0.1%	**98.8%**	98.8%	99.0%
Oral Cavity Code 1	**<0.1%**	<0.1%	0.1%	**<0.1%**	<0.1%	<0.1%	**98.8%**	98.8%	99.0%
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%

[1] Element Omission displays the percentage of records with values present in the PAHPs' submitted files but not in HHS' submitted files.

[2] Element Surplus displays the percentage of records with values present in HHS' submitted files but not in the PAHPs' submitted files.

[3] Element Missing Values displays the percentage of records with values missing from both HHS' submitted files and PAHPs' submitted files.

[4] The results are derived from comparing all five tooth surface field values that were submitted.

[5] The results are derived from comparing all five oral cavity code field values that were submitted.

Table 7-22 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 7-22—Data Element Accuracy: By PAHP

Key Data Element	Element Accuracy[1]		
	Overall Rate	**DDIA**	**MCNA**
Member ID	**>99.9%**	99.9%	100.0%
Header Service From Date	**99.9%**	99.9%	99.8%
Header Service To Date	**99.9%**	>99.9%	99.8%
Detail Service From Date	**99.9%**	99.9%	99.9%
Detail Service To Date	**99.9%**	99.9%	99.9%
Billing Provider NPI	**94.8%**	95.0%	94.1%
Rendering Provider NPI	**96.5%**	95.4%	100.0%
CDT Code	**98.3%**	99.3%	95.2%
Units of Service	**97.1%**	96.5%	98.8%
Tooth Number	**98.7%**	99.6%	96.3%
Tooth Surface 1-5[2]	**98.9%**	NA	98.9%
Tooth Surface 1	**99.0%**	NA	99.0%
Tooth Surface 2	**99.4%**	NA	99.4%
Tooth Surface 3	**99.5%**	NA	99.5%
Tooth Surface 4	**99.8%**	NA	99.8%
Tooth Surface 5	**99.8%**	NA	99.8%
Oral Cavity Code 1-5[3]	**93.3%**	92.5%	96.5%
Oral Cavity 1	**93.3%**	92.5%	96.5%
Oral Cavity 2	**NA**	NA	NA
Oral Cavity 3	**NA**	NA	NA
Oral Cavity 4	**NA**	NA	NA
Oral Cavity 5	**NA**	NA	NA
Detail Paid Amount	**97.7%**	98.6%	94.6%
Header Paid Amount	**98.9%**	>99.9%	95.7%

[1] Element Accuracy displays the percentage of records with the values present and having identical values in both PAHPs' submitted files and HHS' submitted files.

[2] The results are derived from comparing all five tooth surface field values that were submitted.

[3] The results are derived from comparing all five oral cavity code field values that were submitted.
NA indicates that there were no matched records for that data element.

Table 7-23 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing or non-missing) for all key data elements associated with the dental encounter data type.

Table 7-23—All-Element Accuracy: By PAHP

PAHP	Denominator	Numerator	Rate
DDIA	1,891,134	1,459,655	77.2%
MCNA	605,930	508,472	83.9%
Overall	**2,497,064**	**1,968,127**	**78.8%**

Note: The denominator for the all-element accuracy rate is defined differently from the denominators for the individual element accuracy rates since it includes data elements even if values are missing in both sources. If any of the data elements are an element omission, element surplus, or an inaccurate value match, the record will not be a positive hit for the all-element accuracy numerator.

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 2022 NCQA national averages to determine if the results were statistically significantly higher or lower than the 2022 NCQA national averages. Arrows in the tables note statistical significance.

Table 7-24 and Table 7-25 present the 2023 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 7-24—2023 MCO Adult CAHPS Comparisons

	AGP	ITC	MCO Program
Composite Measures			
Getting Needed Care	83.6%	86.5% ↑	85.3% ↑
Getting Care Quickly	79.1%	85.0% ↑	82.7%
How Well Doctors Communicate	90.9%	93.7%	92.6%
Customer Service	NA	90.4%	92.2% ↑
Global Ratings			
Rating of All Health Care	58.3%	57.4%	57.8%
Rating of Personal Doctor	68.3%	72.0%	70.5%
Rating of Specialist Seen Most Often	59.5% ↓	61.9%	60.9% ↓
Rating of Health Plan	54.4% ↓	62.7%	59.5%

	AGP	ITC	MCO Program
Medical Assistance With Smoking and Tobacco Use Cessation Items*			
Advising Smokers and Tobacco Users to Quit	69.9%	68.2%	68.9%
Discussing Cessation Medications	46.0%	45.1%	45.5% ↓
Discussing Cessation Strategies	39.9%	40.8%	40.4%

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 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.

Table 7-25—2023 MCO Child CAHPS Comparisons[7-3]

	AGP	ITC	MCO Program
Composite Measures			
Getting Needed Care	89.7% ↑	87.4%	88.4% ↑
Getting Care Quickly	90.9% ↑	89.4%	90.1% ↑
How Well Doctors Communicate	94.2%	95.8%	95.1%
Customer Service	NA	87.2%	85.4%
Global Ratings			
Rating of All Health Care	66.2%	66.4%	66.3% ↓
Rating of Personal Doctor	78.2%	77.0%	77.5%
Rating of Specialist Seen Most Often	NA	64.9%	70.0%
Rating of Health Plan	71.5%	67.7% ↓	69.3%

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 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.

Scorecard

HHS contracted with HSAG in 2023 to develop a scorecard to evaluate the performance of Iowa Medicaid MCOs. The Iowa Medicaid scorecard demonstrates how the MCOs compare to 2023 NCQA Quality Compass®,[7-4] national Medicaid health maintenance organization (HMO) benchmarks in key

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[7-3] Since **Iowa Total Care** 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.

[7-4] Quality Compass® is a registered trademark of the National Committee for Quality Assurance.

performance areas. The tool uses stars to display results for the MCOs, as shown in Table 7-26. Please refer to Appendix A for the detailed methodology used for this tool.

Table 7-26—Iowa Medicaid Scorecard Results—MCO Scorecard Performance Ratings

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

Table 7-27 displays the 2023 Iowa Medicaid Scorecard results for each MCO.

Table 7-27—2023 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	★★★	★★★★	★★★	★★	★★★	★★★★
MOL	*New	*New	*New	*New	*New	*New

*Due to **Molina of Iowa** being a new plan in 2023, data are not available yet. **Molina of Iowa** will be included in future scorecards.

For 2023, **Amerigroup** demonstrated the strongest performance by achieving High Performance for four of the six reporting categories (*Access to Preventive Care, Women's Health, Living With Illness,* and *Behavioral Health*) and Average Performance for two of the six reporting categories (*Doctors' Communication and Patient Engagement* and *Medication Management*). **Iowa Total Care** demonstrated average performance by achieving High Performance for two of the six reporting categories (*Access to Preventive Care* and *Medication Management*), Average Performance for three of the six reporting categories (*Doctors' Communication and Patient Engagement, Women's Health,* and *Behavioral Health*), and Low Performance for one of the six reporting categories (*Living With Illness*). Opportunities for improvement exist, with both MCOs having Average Performance in at least two 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 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 specifically aligned 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 Program Area	Overall Performance Impact	Performance Domain
Behavioral Health	**Conclusions:** Through the HEDIS results, the Iowa Managed Care Program demonstrated that members seen in the ED and hospitalized for mental illness were receiving timely follow-up care, as all rates ranked at or above the 90th percentile for the *Follow-Up After ED Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness* measures. These results support HHS' MCO Quality Strategy goal: *Promote behavioral health by measuring follow-up after hospitalization/follow-up after emergency department visit (FUH/FUM) for pediatric and adult populations* and indicate that the MCOs implemented policies, procedures, and care coordination processes to ensure members received appropriate follow-up services after an ED visit or hospitalization for mental illness. However, for adult members who have co-occurring physical and mental health diagnoses (i.e., diabetes and schizophrenia or diabetes and bipolar disorder) and children and adolescents prescribed antipsychotics, HEDIS results indicate opportunities for the Iowa Managed Care Program to focus efforts on improving the management of these conditions. **Recommendations:** Due to the success of the behavioral health-related pay-for-performance measure (i.e., *Follow-Up After*	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal Program Area	Overall Performance Impact	Performance Domain
	Hospitalization for Mental Illness), HHS should consider expanding or replacing its existing pay-for-performance measures to include one or more of the lower-performing HEDIS measures (e.g., *Metabolic Monitoring for Children and Adolescents on Antipsychotics*). Additionally, or alternatively, HHS could mandate the MCOs to conduct a PIP that focuses on improving the management of children and adolescents on antipsychotics and/or adults who have co-occurring physical and mental health diagnoses. Further, HHS' existing MCO Quality Strategy does not include measurable performance metrics for most goals. Therefore, HHS should establish minimum performance standards or performance thresholds for each behavioral health -related goal and objective. Establishing a statewide performance benchmark will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress in meeting HHS' established MCO Quality Strategy goals and objectives. Finally, HHS should require calculation of the mandatory CMS Core Set measures by MCO. HHS could accomplish this by requiring its MCOs to calculate and report on each mandatory Core Set measure or contract with its existing vendor to calculate each mandatory Core Set measure by MCO, in addition to calculating the statewide aggregate rates for each measure.	
Access to Care **Improving Coordinated Care**	**Conclusions:** Based on HEDIS results, many adult and child members were accessing preventive medical care, as indicated by most applicable measure rates under the Access to Preventive Care and Keeping Kids Healthy domains performing at or above the national Medicaid 50th percentile. HEDIS results, as indicated by performance at or above the national Medicaid 50th percentile, also indicated that many child and adolescent members were receiving recommended immunizations. Additionally, as indicated through performance under the Women's Health domain, many adult and adolescent women were getting screened for breast cancer and/or cervical cancer, and under the Keeping Kids Healthy domain, many children were getting lead screenings as recommended. Further, under the Living With Illness domain, performance measure rates indicated that many members with diabetes and hypertension were being managed appropriately, as indicated by performance at or above the national Medicaid 50th percentile. These positive results indicate that members were able to access providers to obtain services, which was supported by positive member experiences (i.e., performance at or above 82.7 percent) in the *Getting Needed Care* and *Getting Care Quickly* statewide adult and child CAHPS results. These results also support that progress was made toward	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal Program Area	Overall Performance Impact	Performance Domain
	the Iowa Managed Care Program achieving the objective to *increase access to primary care and specialty care*. HHS also required the MCOs to develop a PIP that focused on timeliness of postpartum care. As indicated by the statewide rate for the *Prenatal and Postpartum Care—Postpartum Care* measure, the Iowa Managed Care Program is performing at or above the national Medicaid 50th percentile, indicating that women who had recently delivered were following up in a timely manner with their providers. Timely and adequate postpartum care can support positive health outcomes for new mothers and their infants. This higher performance also supports the Iowa Managed Care Program's progress toward achieving the *improve timeliness of postpartum care* objective under the Access to Care goal and the *improve the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes* objectives under the Improving Coordinated Care goal. However, there are opportunities to improve the number of members accessing preventive dental care, as 71.57 percent of DWP Adults, 46.28 percent of DWP Kids, and 61.21 percent of Hawki members obtained preventive dental services. Results of the NAV secret shopper survey activity indicated that only 39 percent of dental providers accepted new patients, and new patients had an average wait time of 61 days to get a cleaning appointment. These results may suggest that there were barriers to members accessing preventive dental services. The Iowa Managed Care Program's improvement in this program area will support progress toward achieving Goal 1 to *improve network adequacy and availability of services* and Goal 2 to *increase recall and preventive services*. **Recommendations:** As HHS has separate and distinct quality strategies for the MCOs and PAHPs, to support integration of the medical and dental programs, HSAG continues to recommend that HHS consider combining its separate quality strategies to include all programs supported by the MCOs and PAHPs. Additionally, HHS' existing MCO Quality Strategy does not include measurable performance metrics for most goals. Therefore, HHS should establish minimum performance standards or performance thresholds for each access and coordinated care-related goal and objective. Establishing a statewide performance benchmark will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress in meeting HHS' established MCO Quality Strategy goals and objectives. Further, HHS should focus improvement efforts with the PAHPs on the selected dental measures to advance Goal 1 and Goal 2 of the	

Quality Strategy Goal Program Area	Overall Performance Impact	Performance Domain
	PAHP Quality Strategy to ensure that the DWP and Hawki programs meet HHS' CY 2024 goals. HHS could consider providing the PAHPs with the case-level data files and a timeline for each PAHP to address discrepancies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers and addresses, PAHP and Iowa Medicaid acceptance, new patient acceptance, and/or provider specialty information). Also, in addition to updating provider information, HHS should require the PAHPs to conduct a root cause analysis to identify the cause for the data discrepancies, and HHS should consider requiring the PAHPs to conduct a review of the offices' eligibility verification requirements to ensure that any barriers identified do not hinder members' ability to access dental care. Finally, HHS should require its PAHPs and its MCOs to conduct routine secret shopper surveys of their provider networks to assess compliance with network adequacy and appointment availability standards.	
Voice of the Customer	**Conclusions:** The MCOs obtained CAHPS vendors to administer the CAHPS survey annually in support of HHS' Voice of the Customer Goal and specifically, to *annually review the CAHPS results and make recommendations for improvements*. Based on the statewide results of the CAHPS survey, the adult Medicaid population reported positive experiences in *Getting Needed Care* and *Customer Service*, as these scores (85.3 percent and 92.2 percent, respectively) were statistically significantly higher than the 2022 NCQA Adult Medicaid national average. For the child Medicaid population, the scores for *Getting Needed Care* and *Getting Care Quickly* were both statistically significantly higher than the 2022 NCQA Child Medicaid national average, with scores of 88.4 percent and 90.1 percent, respectively. However, for the adult Medicaid population, the top-box score for *Rating of Specialist Seen Most Often* was 60.9 percent and had a statistically significant decline, which suggests that some members may have been deterred from going to their specialists for care based on their negative personal experiences. Additionally, the top-box scores for *Discussing Cessation Medications* for the adult population and *Rating of All Health Care* for the child population were statistically significantly lower than the 2022 national average, indicating that additional opportunities exist for improving member experience in these areas. In addition to annually reviewing the CAHPS results, HHS also required the MCOs to conduct a PIP with the topic *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed.* Both MCOs received an overall validation rating of *Met*, indicating the MCOs conducted	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal Program Area	Overall Performance Impact	Performance Domain
	appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement, although both MCOs had a statistically significant decline in performance from the baseline measurement rate for CY 2023. **Recommendations:** HHS' existing MCO Quality Strategy does not include measurable objectives that promote performance improvement. Therefore, HHS should establish minimum performance standards or performance thresholds for each Voice of the Customer-related objective. For example, HHS could set minimum performance standards for specific areas or domains of the CAHPS survey. Establishing a statewide performance benchmark will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress toward meeting HHS' established MCO Quality Strategy goals and objectives. Additionally, as HHS' PAHP Quality Strategy does not specifically address member experience, HHS could consider setting a PAHP performance objective under the Voice of the Customer overarching goal. HHS could also consider requiring the PAHPs to contract with a CAHPS vendor to administer a CAHPS survey that has been modified to address dental care.	
Health Equity	**Conclusions:** The CY 2023 EQR activity results (i.e., PIP, PMV, compliance review, NAV, EDV, and CAHPS) did not produce data to comprehensively evaluate the Iowa Managed Care Program's performance impact on health equity with the MCOs in support of the Health Equity goal within the MCO Quality Strategy or the PAHPs in support of Goal 3, *improve oral health equity among Medicaid members*, of the PAHP Quality Strategy. **Recommendations:** HHS' existing MCO Quality Strategy does not include measurable objectives that promote performance improvement. Therefore, HHS should establish objectives with minimum performance standards or performance thresholds that address health equity and target specific program areas where inequities are identified. HHS could also consider requiring a health equity focus for the next cycle of new PIPs for both the MCOs and PAHPs.	☒ Quality ☐ Timeliness ☐ Access

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

PIP activities for CY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in CMS EQR *Protocol 1. Validation of Performance Improvement Projects,* October 2019.[A-1] With the release of the new protocols, HSAG updated its PIP worksheets for CY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the PAHP conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.) For future validations, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[A-2]

HSAG's validation of PIPs includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the 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

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[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: Feb 7, 2024.

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 7, 2024.

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).

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 *Me*t 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 rating (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 2023, the MCOs submitted Remeasurement 2 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 Remeasurement 1 data for their continued PIP topics. The PAHPs used HHS-defined specifications in collecting their performance indicator data. The measures used for MCP PIPs were related to the domains of quality of care and access to care.

HSAG obtained the data needed to conduct the PIP validation from the 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
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? 2. Do targeted interventions increase the percentage of Hawki (Hawki) members 18 years of age and younger who had at least one preventive dental visit during the measurement year? 3. Do targeted interventions increase the percentage of Dental Wellness Plan Kids (DWP Kids) members 18 years of age and younger who had at least one preventive dental visit during the measurement year	Sampling was not used.	• Administrative claims/encounters
MCNA PIP Topic	**Aim Statements**	**Sampling Methods**	**Data Sources**
Increase the Percentage of Dental Services	1. Do targeted interventions increase the percentage of Dental Wellness Plan (DWP Adults) members 19 years and older who had at least 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 all (MCPs) and to determine the extent to which performance measures reported by the MCPs follow State specifications and reporting requirements. HSAG also followed the guidelines set forth in CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.[A-3]

HHS identified a set of performance measures for CMS Core Set reporting that it wanted to include in the validation activity. HHS also identified a set of performance measures that the PAHPs were required to calculate and report, which 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

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[A-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 7, 2024.

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 and the HHS vendor, IBM.[A-4] HSAG collected information using several methods including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual review activities included the following:

- **Opening and organizational review**—This interview session included introductions of HSAG's validation team and key MCP or IBM staff involved in the support of the MCPs' and IBM's information systems and its calculation and reporting of the performance measures. HSAG reviewed expectations for the virtual review, discussed the purpose of the PMV activity, and reviewed the agenda and general audit logistics. This session also allowed the MCPs and IBM to provide an overview of its organizational operations and any important factors regarding its information systems or performance measure activities.
- **Review of key information systems and data processes**—Drawing heavily on HSAG's desk review of the MCPs' and IBM's ISCAT responses, these interview sessions involved key MCP or IBM staff responsible for maintaining the information systems and executing the processes necessary to produce the performance measure rates. HSAG conducted interviews to confirm findings based on its documentation review, expanded, or clarified outstanding questions, and ascertained that written policies and procedures were used and followed in daily practice. Specifically, HSAG staff evaluated the systems and processes used in the calculation of selected performance measures.
    - **Enrollment, eligibility, provider, and claims/encounter systems and processes**—These evaluation activities included a review of key information systems and focused on the data systems and processes critical to the calculation of measures. HSAG conducted interviews with key staff familiar with the collection, processing, and monitoring of the MCP data used in producing performance measures.
    - **Overview of data integration and control procedures**—This session included a review of the database management systems' processes used to integrate key source data and the PAHPs' and IBM's calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate

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[A-4] IBM was included as part of the PMV activity with the MCOs as IBM calculated CMS Core Set Reporting performance measure rates at the statewide level during encounter data submitted to HHS by the MCOs. The PAHP PMV activity was conducted separate from the MCO and IBM PMV activity.

  calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
  - **System demonstrations**—HSAG staff requested that MCP and IBM staff demonstrate key information systems, database management systems, and analytic systems to support documented evidence and interview responses.
- **PSV**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across evaluated measures to verify that the PAHPs and IBM had appropriately applied measure specifications for accurate rate reporting. The PAHPs and IBM provided HSAG with a listing of the data the MCPs had reported to HHS from which HSAG randomly selected a sample of cases and requested that the MCPs provide proof of service documentation.

Description of Data Obtained and Related Time Period

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

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

Table A-5 shows the data sources used in the validation of performance measures and the periods to which the data applied. IBM's information has been included to demonstrate its involvement in the MCO PMV.

Table A-5—Description of MCO and IBM Data Sources

Data Obtained	Time Period to Which the Data Applied		
	AGP	ITC	IBM
Completed ISCAT	MY 2022 (January 1, 2022, to December 31, 2022)		
Source code for each performance measure			
Performance measure results			
Supporting documentation			
Virtual on-site interviews and systems demonstrations	October 17, 2023	October 16, 2023	October 26, 2023

Additionally, HHS provided HSAG with each MCO's audited MY 2022 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 PAHP 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 2023 (July 1, 2022, to June 30, 2023)	
Source code for each performance measure		
Performance measure results		
Supporting documentation		
Virtual on-site interviews and systems demonstrations	October 3, 2023	October 5, 2023

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that the MCPs provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, *Not Applicable*, or *Not Reported*. HSAG further analyzed the quantitative results (e.g., performance indicator results) and qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. For each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members. Additionally, for each

MCO's audited MY 2022 HEDIS rates for HHS-selected measures, strengths were identified as a greater than 5 percent improvement from the prior year or a rate that was above the national Medicaid 75th percentile. Weaknesses were identified as a greater than 5 percent decline from the prior year or a rate that fell at or below the national Medicaid 25th percentile.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the 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 Managed Care Program members. HSAG followed the guidelines set forth in CMS' *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*, February 2023.[A-5]

HHS requires its MCPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. CY 2021 began a new three-year compliance review cycle, in which HSAG reviewed the first half of the federal standards for compliance. The remaining federal standards were reviewed in CY 2022. The objective of the CY 2023 compliance review was to perform a comprehensive evaluation of the MCPs' implementation of corrective actions taken to remediate any requirements (i.e., elements) that received a *Not Met* score during the first two years of the compliance review cycle (CYs 2021 and 2022).

As demonstrated in Table A-7, HSAG completed a comprehensive review of compliance with all federal requirements as stipulated in 42 CFR §438.358 within a three-year period.

Table A-7—Iowa Compliance Review Three-Year Cycle for MCPs

Standards	Associated Federal Standards[1]		Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of each MCP's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		

[A-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 29, 2024.

Standards	Associated Federal Standards[1]		Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
	Medicaid	CHIP			
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b)	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1110 §457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240(b)		✓	

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

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

At the conclusion of the CY 2023 compliance reviews, for any CAP elements scored *Not Complete*, the MCPs were required to participate in mandatory technical assistance meetings with HHS and HSAG to further discuss the requirement(s), expectations, and appropriate action plans to bring the element(s) into compliance. The MCPs were required to update their existing CAP(s) and applicable action plans to align with the expectations addressed during the technical assistance meeting, and subsequently follow HHS's and HSAG's direction and implement timely interventions to fully remediate the remaining action plans. HSAG will review the MCPs' implementation of the open CAPs during the next three-year cycle of compliance reviews.

Technical Methods of Data Collection and Analysis

Prior to beginning the CY 2023 compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the findings from the review. The content of the tools was selected based on applicable federal and State regulations and on the requirements set forth in the contract between HHS and the MCPs as they related to the scope of the review, which included a review of each MCP's implementation of its CAP for each element that received a deficiency during the CY 2021 and CY 2022 compliance reviews and standard. HSAG also followed the guidelines set forth in CMS EQR Protocol 3.

For each MCP, HSAG's desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with HHS to develop scope of work, compliance review methodology, and compliance review tools (i.e., CAP review tool).
- Prepared and forwarded to the MCP a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the MCPs.
- Hosted a pre-site review preparation session with all MCPs.
- Conducted a desk review of supporting documentation the MCP submitted to HSAG.
- Followed up with each MCP, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the site review interview sessions and provided the agenda to the MCP to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCP key program staff members.
- Conducted an IS review of the data systems that the MCP used in its operations, applicable to the standards and elements under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the MCP.
- Documented findings and assigned each element a score of *Complete* or *Not Complete* for the CAP review (as described in the Data Aggregation and Analysis section) within the compliance review tool.
- Prepared an MCP-specific report detailing the findings of HSAG's review.
- Conducted a mandatory technical assistance meeting with each MCP, as applicable, to review any CAP element that received a score of *Not Complete*.

Data Aggregation and Analysis:

For the CAP review, HSAG used scores of *Complete* and *Not Complete* to indicate the degree to which the MCP's performance complied with the requirements. The scoring methodology is outlined below:

Complete indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

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

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file documentation, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Complete* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

As part of the CAP review for all MCPs, HSAG conducted file reviews of each MCP's records for the program areas under review (e.g., case management, prior authorization denials, credentialing, appeals) to verify that the MCP had put into practice what it had documented in policies and procedures. The file reviews were not intended to be a statistically significant representation of 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 was expected to determine whether any area found noncompliance was the result of an anomaly or if a more serious breach in policy had occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tools.

From the scores that it assigned for each of the requirements, HSAG determined the number of *Complete/Not Complete* elements (for the CAP review) to calculate a total compliance score for each standard under review and an overall compliance score.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided to members within the program areas under review, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCP's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCP's performance for each requirement.

- The total compliance score calculated for each of the standards included as part of the CY 2023 compliance review.
- The overall compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Complete* (CAP review).
- Documented recommendations for program enhancement, when applicable.

Description of Data Obtained

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

- CAP workplans and timelines
- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- Management/monitoring reports and audits
- Narrative and/or data reports across a broad range of performance and content areas
- Case files for prior authorization denials, care plans, credentialing and recredentialing records, grievance records, appeal records, contracts with delegated entities, etc.

HSAG obtained additional information for the compliance review through IS reviews of the MCP's data systems and through interactions, discussions, and interviews with the MCP's key staff members. Table A-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 and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review	CAP Review—Documentation effective as of the document submission date (i.e., July 11, 2023), including requested case files.
Information obtained through interviews	August 2, 2023–August 3, 2023
Documentation submitted post-site review	August 4, 2023–August 7, 2023

Process for Drawing Conclusions

For the CAP review, to draw conclusions and provide an understanding of the strengths and weaknesses for each MCP individually, HSAG used the quantitative results (i.e., number of *Complete* and *Not Complete* elements) score calculated for each standard. As any element not achieving compliance required a formal action plan, HSAG determined each MCP's substantial strengths and weaknesses as follows:

- Strength—Any program area in which the MCP received a *Complete* score for all elements.
- Weakness—Any program area with one or more elements with a *Not Complete* score.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that the MCP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members

Network Adequacy Validation

Activity Objectives

The goal of the network adequacy projects was to ensure the MCPs' members have adequate access to healthcare services. HSAG's approach to conducting the NAV activity is tailored to address the specific needs of its client by focusing on topics selected by HHS and outlined in CMS EQR Protocol 4. Full alignment with CMS EQR Protocol 4 is required for the EQR technical report that will be published in April 2025. For the MCOs, HSAG assessed the pediatric members' access to behavioral health providers.

Technical Methods of Data Collection and Analysis

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.

The member population was limited to pediatric Hawki and Iowa Health Link members residing within the State of Iowa. Pediatric behavioral health members were identified as those under 19 years of age on December 31, 2022. Members were further limited to those continuously enrolled in Hawki or Iowa Health Link during the lookback and measurement years with no more than a one-month lapse in each year.

Members were identified as behavioral health patients in the lookback and measurement years if they had one or more visits to a behavioral health provider in either year. Any pediatric member who had an encounter with a provider in any behavioral health specialty during the study period (the lookback and measurement years) was considered a behavioral health patient in that year. New behavioral health patients were those who had one or more behavioral health encounters in the measurement year but none in the lookback year; continuing patients were those with encounters in both years; non-continuing patients were those with encounters only in the lookback year; and non-patients were those with no visits in the measurement year. Note that the status of a member as a new behavioral health patient was not affected by whether visits were inpatient or outpatient; for example, a member with an inpatient behavioral health visit in the lookback year and an outpatient behavioral health visit in the measurement year was not considered a new patient since he or she had behavioral health visits in both years.

Inpatient behavioral health providers were limited to facilities and hospital units, such as substance use disorder (SUD) residential rehabilitation/treatment facilities, psychiatric residential treatment facilities, hospital psychiatric units, and skilled nursing facilities with mental health care. Outpatient providers were limited to individual professionals such as licensed mental health counselors, certified alcohol and drug counselors, psychiatrists (MDs), psychiatric mental health nurse practitioners (NPs), psychologists, social workers/clinical social workers, licensed marriage and family therapists, and behavioral analysts. Providers were identified as facilities, medical groups, or individuals based on a Provider Indicator supplied by the MCOs in their provider network data files. Provider specialties were identified based on the provider type, provider specialty, and provider taxonomy fields provided by **Amerigroup** and **Iowa Total Care** in their provider network data files. Only providers flagged as behavioral health providers by the MCOs and identified by HSAG as inpatient or outpatient providers based on the fields listed above were included in the analysis. Providers with ambiguous or contradictory data fields were reviewed by the analytic team, who made decisions about classification and inclusion/exclusion. HSAG identified behavioral health encounters as those wherein at least one of the rendering, attending, or billing provider NPIs associated with the encounter was identified as belonging to an inpatient or outpatient behavioral health provider.

Encounter end dates were used to establish the timing of each encounter. Encounters with end dates on or after January 1, 2021, and on or before December 31, 2022, were included in the analysis. For members with no visits in 2021, the earliest pediatric behavioral health encounter with an end date in 2022 was considered a new behavioral health patient visit. All providers associated with encounters with the member on the date of the visit were considered to have had a visit. Additionally, all encounters were included regardless of whether the claim was paid or denied by the MCO.

For analyses centered on providers, encounters were attributed to the MCO and program in which the member was enrolled at the time of the encounter.

Once the data files were received and processed for inclusion in the analysis, HSAG conducted the following analyses:

- **Percentage of behavioral health providers with new pediatric patients:** This dimension assessed the number of contracted behavioral health providers in the measurement year (CY 2022) with visits from one or more pediatric members who did not have a behavioral health visit in the lookback year (CY 2021) and the percentage of all behavioral health providers that had such visits. Results were tabulated separately for inpatient and outpatient providers.
- **Average number of new pediatric patients among behavioral health providers:** This dimension evaluated the distribution of new pediatric members seen by contracted behavioral health providers and the average (mean) and median numbers of new members per provider as summary measures. Results were tabulated separately for inpatient and outpatient providers.
- **Percentage of members that are new pediatric behavioral health patients:** This dimension assessed the number and percentage of pediatric members with new behavioral health visits during

the measurement year compared with members with visits in both years, those with visits only in the lookback year, and those with no visits in either year.

- **Geographic and demographic characteristics of new pediatric behavioral health patients:** This dimension showed tabulations of new patient status by members' urban/rural residential location, race, ethnicity, and sex, with comparisons between pediatric members with new behavioral health visits during the measurement year and members with visits in both years, those with visits only in the lookback year, and those with no visits in either year.

Description of Data Obtained and Related Time Period

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:

- Member demographic data, including key data elements such as unique member identifier, sex, age, race, ethnicity, and residential address as of December 31, 2022.
- Member eligibility and enrollment data, including start and end dates for MCO and program enrollment for all enrollment spans during CY 2021 and CY 2022.
- Encounter data for CY 2021 and CY 2022 for medical services with service ending dates between January 1, 2021, and December 31, 2022.
- Provider data, including key data elements such as NPI, provider type and specialty, taxonomy, and office location addresses as of December 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 pediatric members' access to behavioral health providers. 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 MCO's Medicaid managed care members.

Secret Shopper Survey

Activity Objectives

The primary purpose of the CY 2023 secret shopper survey was to collect dental appointment availability for a dental cleaning for Medicaid patients new to the provider location. As a secondary survey objective, HSAG evaluated the accuracy of selected provider data elements related to members' access to dental care. Specific survey objectives included the following:

- Determine if the contact information (i.e., phone number and address) was accurate for the dental providers reported by the PAHPs as being contracted providers.
- Determine whether dental service locations accepted patients enrolled with the requested PAHP for the DWP, DWP Kids, or Hawki programs and the degree to which PAHP and program acceptance aligned with the PAHPs' provider data.
- Determine whether dental service locations that accepted the program for the requested PAHP accepted new patients and the degree to which new patient acceptance aligned with the PAHPs' provider data.
- Determine appointment availability with the sampled dental service locations for preventive dental care.

Technical Methods of Data Collection and Analysis

To address the survey objectives, HSAG used an HHS-approved methodology and script to conduct a secret shopper telephone survey of provider offices contracted with one or more PAHP. The secret shopper approach allows for objective data collection from healthcare providers without potential bias introduced by revealing the surveyors' identities. Using the provider data supplied to HSAG by each PAHP, secret shopper callers contacted sampled provider locations between September and October 2023 to inquire about appointment availability for a dental cleaning. Table A-9 lists the PAHPs that participated in this study and submitted provider data files to HSAG.

Table A-9–Iowa PAHPs

PAHP Name	PAHP Short Name	Contracted Programs
Delta Dental of Iowa	**Delta Dental** or **DDIA**	DWP, DWP Kids, and Hawki
Managed Care of North America Dental	**MCNA Dental** or **MCNA**	DWP and DWP Kids

Eligible Population

The eligible population included service locations associated with dental providers actively contracted with the PAHP to serve individuals enrolled in the Medicaid program, at the time the data file was created. Service locations with addresses outside of Iowa were included in the sample frame if they were contracted with an Iowa PAHP.

Using an HHS-approved data request document, each PAHP identified general dental providers potentially eligible for survey inclusion and submitted the provider data files to HSAG. HSAG then reviewed the data to ensure alignment with the requested data file format, data field contents, and logical consistency between data elements. To reduce the likelihood of sampling the same provider locations within and between the PAHPs, HSAG standardized the providers' address data to align with the United States Postal Service Coding Accuracy Support System (CASS).

Sampling Approach

Cases were sampled by unique telephone number. If a phone number was associated with multiple addresses within a PAHP, HSAG randomly assigned the number to a single PAHP and standardized address, prioritizing assignment to the least-represented PAHP.

During the survey, HSAG's callers used an HHS-approved script to complete survey calls to all sampled provider locations, recording survey responses in an electronic data collection tool.

Several limitations and analytic considerations must be noted when reviewing secret shopper telephone survey results:

- Survey calls were conducted at least four weeks following HSAG's receipt of each PAHP's provider data, resulting in the possibility that provider locations updated their contact information with the PAHP prior to HSAG's survey calls.
- Survey findings were compiled from self-reported responses supplied to HSAG's callers by provider office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication.
- Time to the first available appointment is based on appointments requested with the sampled provider location. Cases were counted as being unable to offer an appointment if the case offered an appointment at a different location. As such, survey results may underrepresent timely appointments for situations in which Iowa Medicaid members are willing to travel to an alternate location.
- To maintain the secret nature of the survey, callers posed as members who were new patients at the sampled provider locations. As such, survey results may not represent appointment timeliness among members who are existing patients with these provider locations.

Description of Data Obtained and Related Time Period

HSAG completed the survey calls during September and October 2023. Prior to analyzing the results, HSAG reviewed the responses to ensure complete and accurate data entry.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each PAHP provided to members, HSAG analyzed the results of the activity to determine each PAHP's substantial strengths and weaknesses by assessing (1) which dental service locations accepted DWP, DWP Kids, or Hawki program members enrolled with the requested PAHP for the Medicaid program and the degree to which PAHP and Medicaid acceptance aligned with the PAHPs' provider data, (2) whether dental service locations accepting Medicaid for the requested PAHP accepted new patients and the degree to which new patient acceptance aligned with the PAHPs' provider data, and (3) appointment availability with the sampled dental service locations for preventive dental visits.

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCEs so as to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. During CY 2023, HHS contracted HSAG to conduct an EDV study for both the MCOs and the PAHPs. HSAG's approach to conducting EDV studies is tailored to address the specific needs of its clients by customizing elements outlined in CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023.[A-6]

MCOs

For CY 2023, HSAG conducted the following two core evaluation activities:

- **Information Systems (IS) Review**—assessment of the MCOs' information systems and processes. The goal of this activity is to examine the extent to which the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to *Activity 2: Review the MCP's Capability* in the CMS EQR Protocol 5.
- **Targeted Comparative Analysis**—analysis of HHS' electronic encounter data completeness and accuracy through a comparison between HHS' electronic encounter data and the data extracted from the MCOs' data systems. The goal of this activity is to evaluate the extent to which the encounter data in HHS' data warehouse that were submitted by the MCOs are complete and accurate. This activity corresponds to *Activity 3: Analyze Electronic Encounter Data*, in the CMS EQR Protocol 5. The analysis will target an evaluation of a known provider enrollment issue that would have affected the accuracy and completeness of HHS' encounter data. The analysis will seek to identify the gap(s) as a result of the issue.

Since this was the first year in which HSAG conducted an EDV study for **Molina of Iowa**, HSAG conducted an IS review with **Molina of Iowa** in CY 2023. For **Amerigroup** and **Iowa Total Care**, HSAG had previously conducted an IS review (in CY 2016 and CY 2019, respectively). As such, HSAG did not conduct an IS review for these two MCOs. Due to HHS' concerns regarding known provider enrollment issues and their potential impact on the accuracy and completeness of submitted encounters, HSAG conducted a targeted comparative analysis to evaluate the extent to which encounters within HHS' data warehouse were being affected by this issue.

[A-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 7, 2024

PAHPs

For both PAHPs, during CY 2023, HSAG conducted the comparative analysis component of the EDV study. The goal of the comparative analysis is to evaluate the extent to which encounters submitted to HHS by the PAHPs are complete and accurate based on corresponding information stored in each PAHP's data systems. This step corresponds to Activity 3: Analyze Electronic Encounter Data in CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

MCOs

IS Review

To ensure the collection of critical information, HSAG employed a three-stage process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members. Of note, HSAG conducted this activity for **Molina of Iowa** only.

Stage 1—Document Review

HSAG initiated the EDV activity with a desk review of documents related to encounter data initiatives and validation activities currently put forth by HHS. Documents reviewed included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, workgroup meeting minutes, and HHS' current encounter data submission requirements. The information obtained from this review assisted in the development of a targeted questionnaire to address important topics of interest to HHS.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

Based on the information provided by HHS, HSAG developed a questionnaire, customized in collaboration with HHS, to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. This assessment also included a review of supplemental documentation regarding other data systems, including enrollment and providers. Lastly, this review included specific topics of interest to HHS.

Stage 3—Key Staff Member Interviews

After reviewing the completed assessments, HSAG followed up with key information IT personnel to clarify any questions which that stemmed from questionnaire responses. Overall, the IS reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data.

Targeted Comparative Analysis

Both **Amerigroup** and **Iowa Total Care** were included in this component of the EDV activity for CY 2023. In this activity, HSAG developed a data requirements document requesting claims/encounter data from both HHS and the MCOs. A follow-up technical assistance session was held approximately one week after distributing the data requirements documents, thereby allowing the MCOs time to review and prepare their questions for the meeting.

HSAG used data from both HHS and the MCOs with dates of service from July 1, 2021, through June 30, 2022, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources represent the same universe of encounters, the data targeted professional and institutional encounters submitted to HHS on or before February 28, 2023. This anchor date allowed enough time for the encounters to be submitted, processed, and available for evaluation in the HHS data warehouse. HSAG also requested provider enrollment data extract from HHS which was used to evaluate the extent to which encounters within HHS' data warehouse are being impacted as a result of the known provider enrollment issue.

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— Extracted based on the data requirements document.
- Percentage present—Required data fields are present on the file and have values in those fields.
- Percentage of valid values— The values are the expected values; e.g., valid ICD-10 codes in the diagnosis field.
- Evaluation of matching claim numbers—The percentage of claim numbers matching between the data extracted from 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-10. The analyses focused on an element-level comparison for each element.

Table A-10—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional
Member Identification (ID)	✓	✓

Key Data Elements	Professional	Institutional
Dates of Service		
Detail Service From Date	✓	
Detail Service To Date	✓	
Header Service From Date		✓
Header Service To Date		✓
Provider Information		
Billing Provider Information		
Billing Provider National Provider Identifier (NPI)	✓	✓
Legacy Billing Provider Number	✓	✓
Billing Provider Name	✓	✓
Billing Provider Address (i.e., including Zip Code)	✓	✓
Billing Provider Taxonomy Code	✓	✓
Rendering Provider NPI	✓	
Attending Provider NPI		✓
Referring Provider NPI	✓	✓
Diagnosis and Procedure Codes Information		
Primary Diagnosis Code	✓	✓
Procedure Code (Current Dental Terminology [CDT], Current Procedure Terminology [CPT], Healthcare Common Procedure Coding Systems [HCPCS])	✓	✓
Procedure Code Modifier	✓	✓
Units of Service	✓	✓
Surgical Procedure Codes		✓

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).
- The number and percentage of records with values missing from both HHS' data warehouse and the MCOs' submitted files (element missing values).

Element-level accuracy will be limited to those records with values present in both the MCOs' submitted files and HHS' data warehouse. For each key data element, HSAG will determine the number and percentage of records with the same values in both the MCOs' submitted files and HHS' data warehouse (element accuracy).

Finally, for the targeted comparative analysis on the billing provider legacy number, HSAG will analyze and assess the accuracy of HHS' legacy provider number crosswalk based on the following metrics to determine the impact on the encounter data where the crosswalk resulted in inappropriate provider information:

- Legacy provider number in HHS' data was not populated. This occurs when the submitted encounter data was accepted based on the provider tax ID number (TIN) and not the provider NPI, or if there is a one-to-many relationship in the MMIS provider data on NPI or licensed practical nurse (LPN) that was not able to be accurately matched in the encounter data crosswalk.
- Legacy provider number in HHS' data was populated, but the zip codes between the two data sources do not match.
- Legacy provider number in HHS' data was populated, but the taxonomy between the two data sources do not match.
- Legacy provider number in HHS' data was populated, but the provider type does not match the services on the claim (e.g., provider type is dentist, however services on the claims indicate services were associated with the Federally Qualified Health Center [FQHC]; or provider type is Waiver however, services were associated with services that were not in the waiver billing chart).

As a follow-up to the comparative analysis activity, HSAG provided technical assistance to HHS and the MCOs regarding critical issues from the comparative analysis. First, HSAG drafted MCO-specific encounter data discrepancy reports highlighting 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.

PAHPs

Comparative Analysis

HSAG developed a data requirement 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:

- *Record Omission*: Number and percentage of records present in the PAHPs' submitted files but not in HHS' data warehouse.
- *Record Surplus*: Number and percentage of records present in HHS' data warehouse but not in the PAHPs' submitted files.

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 data element.

Table A-11—Key Data Elements for Comparative Analysis

Key Data Elements	Dental
Member ID	✓
Header Service From Date	✓
Header Service To Date	✓
Detail Service From Date	✓
Detail 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:

- *Element Omission*: Number and percentage of records with values present in the PAHPs' submitted files but not in HHS' data warehouse.
- *Element Surplus*: Number and percentage of records with values present in HHS' data warehouse but not in the PAHPs' submitted files.
- *Element Missing Values (i.e., Element Absent)*: Number and percentage of records with values missing from both HHS' data warehouse and the PAHPs' submitted files.

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:

- *Element Accuracy*: The number and percentage of records with the same values in both the PAHPs' submitted files and HHS' data warehouse.
- *All-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.

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

Targeted Comparative Analysis

HSAG used professional and institutional encounter data from HHS and the MCOs with dates of service from July 1, 2021, through June 30, 2022, 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, 2023. 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, 2021, through June 30, 2022, 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 February 28, 2023. 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 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 and accuracy 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 adult members' and parents'/caretakers' of child members experience with an MCO and its providers, and the quality of care they receive. The goal of the CAHPS Health Plan Surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

Two populations were surveyed for the MCOs: adult Medicaid and child Medicaid. Center for the Study of Services (CSS) and SPH Analytics, NCQA-certified vendors, administered the 2023 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-7] The global ratings reflected patients' overall member experience with their personal doctor, specialist, health plan, and all health care. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care*, *How Well Doctors Communicate*). The CCC composite measures/items evaluated the experience of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The 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 rating (i.e., a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box score).

For each of the four composite measures and five CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive or top-box response for the composite measures and CCC composites/items was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite measures and CCC composite measures/items. For the 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 2022 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 2022 NCQA national average. Conversely, a red downward arrow (↓) indicates a top-box score was statistically significantly lower than the 2022 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

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[A-7] **Iowa Total Care** 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.

the other was not. In these instances, it was the difference in the number of respondents between the two MCOs that explained the different statistical results. It is more likely that a statistically significant result will be found in an MCO with a larger number of respondents. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as NA.

Description of Data Obtained and Related Time Period

Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2022, and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2022. Adult members and parents or caretakers of child members completed the surveys from February to May 2023.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each MCO provided to members, HSAG assigned each of the measures to one or more of these three domains and compared each MCO's and the MCO program's (i.e., MCOs combined) 2023 survey results to the 2022 NCQA national averages to determine if there were any statistically significant differences. This assignment to domains is depicted in Table A-12.

Table A-12—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 members must adopt and implement a quality rating system (QRS). While the final technical specifications are not available for the QRS, on May 3, 2023, CMS advised that Medicaid and CHIP (MAC) QRS or alternative QRS should align with the Medicare Advantage and Part D QRS, Marketplace QRS, the Medicaid and CHIP Child Core Set, the Medicaid Adult Core Set, and other similar CMS initiatives such as the Medicaid and CHIP Scorecard and the CMS Universal Foundation. The updated proposed rule includes a mandatory measure list, an initial rating methodology (either CMS' methodology or a CMS-approved alternative methodology has to be used), and the creation of a mandatory website by each state.

The scorecard is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection and Analysis

MCO performance was evaluated in six separate reporting categories, identified as important to consumers.[A-8] 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 on antidepressants and antipsychotics, and children on antipsychotics and medications for ADHD.
- **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 2023 NCQA Quality Compass national Medicaid HMO benchmarks and assigned star ratings for each measure. HSAG used the following methodology to assign a star rating for each individual measure:

[A-8] National Committee for Quality Assurance. "Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports for Consumers." October 1998.

Table A-13—Measure Rate Star Rating Descriptions

Rating	MCO Measure Rate Performance Compared to National Benchmarks
★★★★★	The MCO's measure rate was at or above the national Medicaid HMO 90th percentile
★★★★	The MCO's measure rate was between the national Medicaid HMO 75th and 89th percentiles
★★★	The MCO's measure rate was between the national Medicaid HMO 50th and 74th percentiles
★★	The MCO's measure rate was between the national Medicaid HMO 25th and 49th percentiles
★	The MCO's measure rate was below the national HMO Medicaid 25th percentile

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-14—MCO Scorecard Performance Ratings

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

Description of Data Obtained and Related Time Period

HSAG analyzed MY 2022 HEDIS results, including MY 2022 CAHPS data from two MCOs, **Amerigroup** and **Iowa Total Care**, for presentation in the 2023 Iowa Medicaid Scorecard.