Calendar Year 2021 External Quality Review Technical Report

April 2022

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 of, timeliness of, and access to care and services they provide, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Iowa Department of Human Services (DHS) has contracted with Health Services Advisory Group, Inc. (HSAG), as its external quality review organization (EQRO) to perform the assessment and produce this annual report.

The Iowa Medicaid Enterprise (IME) is the division of DHS that administers and oversees the Iowa Medicaid program, which contracts with two managed care organizations (MCOs) to provide physical health, behavioral health, and long-term services and supports (LTSS) to Medicaid members. Iowa's Medicaid managed care program consists of two primary coverage groups: (1) IA Health Link and (2) Healthy and Well Kids in Iowa, also known as Hawki (Iowa's Children's Health Insurance Program [CHIP]). DHS also contracts with two prepaid ambulatory health plans (PAHPs) to provide dental benefits for Medicaid (Dental Wellness Plan [DWP] Adults and DWP Kids) and Hawki members. The MCOs and PAHPs contracted with DHS during calendar year (CY) 2021 are displayed in Table 1-1.

Table 1-1—MCPs* in Iowa

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

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

Scope of External Quality Review (EQR) Activities

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

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

quality of, timeliness of, and access to care and services. Effective implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective, high-value care and to achieve higher-performing healthcare delivery systems for their Medicaid and CHIP members. For the CY 2021 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each MCP. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MCP used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects*
Performance Measure Validation (PMV)	The activity assesses whether the performance measures calculated by an MCP are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which a Medicaid and CHIP MCP is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations
Network Adequacy Validation (NAV)	This activity assesses the extent to which an MCP has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy**
Encounter Data Validation (EDV)	The activity validates the accuracy and completeness of encounter data submitted by an MCP.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] Analysis	This activity assesses member experience with an MCP and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys
Quality Rating	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***

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

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

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

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

Statewide Findings and Conclusions

HSAG used its analyses and evaluations of EQR findings from the CY 2021 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 Medicaid managed care program. Table 1-3 highlights substantive findings and actionable state-specific recommendations, when applicable, for DHS to target specific goals and objectives in its quality strategy to further promote improvement in the quality, timeliness, and access to health care services furnished to its Medicaid managed care members. Refer to Section 9 for more details.

Table 1-3—Statewide Substantive Findings

Program Strengths
• **Quality** – Performance results for the *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measures demonstrate that the Iowa Medicaid managed care program is reducing the risk of opioid-related overdoses through appropriate and evidence-based prescribing practices. Individuals who receive opioid prescriptions through multiple providers, and at high dosages, are at greater risk of fatal and nonfatal overdoses. The rates for these performance measures suggest that the Iowa Medicaid managed care program is engaged in working with providers to limit access to habit-forming medications when not medically necessary. This finding is further supported through the MCOs' efforts to coordinate care for members diagnosed with alcohol or other drug dependence as supported by high-performing Healthcare Effectiveness Data and Information Set (HEDIS®)[1-3] measure rates and compliance review findings in this program area. This strength within the program supports DHS' progress in achieving the Iowa Medicaid Managed Care Quality Assurance System *Access to Care* goal of *increasing access to primary care and specialty care* and the *Behavioral Health* goal of *assessing the potential for a Substance Use Disorder (SUD) Health Home Program.* – The aggregated adult CAHPS measure score for the Iowa Medicaid managed care program for *Getting Needed Care* was more than 5 percentage points above the national average, indicating that adult Iowa Medicaid managed care members had positive experiences when getting necessary care, tests, or treatments, and scheduling timely appointments with specialists. This strength of the program supports DHS' progress in achieving the Iowa Medicaid Managed Care Quality Assurance System *Access to Care* goal of *increasing access to primary care and specialty care* and the *Voice of the Customer* goal of *annually reviewing CAHPS results and making recommendations for improvement*. – Overall, statewide performance for the Coordination and Continuity of Care standard reviewed as part of the compliance review activity was high, indicating that the program has effective processes for ensuring Iowa's Medicaid managed care members have access to care coordination and care management programs. Additionally, as demonstrated through the PMV activity, Iowa Medicaid managed care members enrolled in a waiver program chose their current care setting, have a goal to live in a less restrictive setting, or were living in the least restrictive setting. This strength of the program supports

[1-3] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Program Strengths

DHS' progress in achieving the Iowa Medicaid Managed Care Quality Assurance System *Continuity of Care* goals of *ensuring the accuracy and completeness of member information needed to efficiently and effectively transition members between plans and/or providers, monitoring long-term care facility documentation to ensure that members choosing to live in the community are able to successfully transition to the community as well as remain in the community,* and *monitoring transition and discharge planning for LTSS members.* This strength further supports the *Improving Coordinated Care* goals of *70 percent of Health Risk Assessments (HRAs) will be completed within 90 days of enrollment and annually thereafter, 100 percent timely completion of level of care and needs-based eligibility assessments,* and *100 percent timely completion of the initial and annual service plan review and updates* and the Iowa PAHP Quality Strategy goal of *providing care coordination to members based on HRAs by monitoring of HRA completion for members continuously enrolled for six months.*

- **Timeliness**
  - Through the State-mandated PIP topic, *Timeliness of Postpartum Care,* the Iowa Medicaid managed care program is focusing efforts on engaging new mothers in accessing timely postpartum care. Postpartum care sets the stage for the health and wellbeing of mothers and babies, as new moms are at risk of serious and life-threatening health complications that can be prevented with timely and adequate postpartum care. Although the statewide performance for *Timeliness of Postpartum Care* is low, by implementing interventions to improve performance, the Iowa Medicaid managed care program is engaged in and focused on reducing the possibility of adverse health outcomes for both mothers and babies. This strength of the program supports DHS' progress in achieving the Iowa Medicaid Managed Care Quality Assurance System *Access to Care* goal of *improving timeliness of postpartum care* and the *Improving Coordinated Care* goal of *improving the postpartum visit rate, postpartum follow-up and care coordination,* and *glucose screening for gestational diabetes.*
  - Performance results for *Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence, Follow-Up After ED Visit for Mental Illness,* and *Initiation and Engagement of AOD Abuse or Dependence Treatment* demonstrate that the Iowa Medicaid managed care program is engaged in providing timely follow-up treatment for members diagnosed with an SUD or a mental illness after an ED visit to improve physical and mental functions and reduce repeat ED visits, hospital admissions and readmissions, and healthcare spending. Additionally, due to the addition of telehealth services to the HEDIS measurement year (MY) 2020 measure specifications, high performance in these measures likely indicates a high adoption rate for telehealth services during the coronavirus disease 2019 (COVID-19) pandemic. This is further supported by the NAV activity, which identified that almost a quarter of Iowa's Medicaid managed care members accessed telehealth services in CY 2020. This strength within the program supports DHS' progress in achieving the Iowa Medicaid Managed Care Quality Assurance System *Behavioral Health* goal of *promoting behavioral health by measuring follow-up after hospitalization/follow-up after emergency department visit for pediatric and adult populations.* It further supports the Iowa Medicaid Managed Care Quality Assurance System *Decrease Cost of Care* goal of *reducing the rate of potentially preventable readmissions and non-emergent ED visits.*
- **Access**
  - As demonstrated through high performance in the Availability of Services and Assurances of Adequate Capacity and Services standards reviewed through the compliance review activity, the Iowa Medicaid managed care program has effective processes in place to maintain and monitor for an adequate provider network that is sufficient to provide adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, LTSS, behavioral health, optometry, lab and x-ray,

Program Strengths

pharmacy, and dental) for the Medicaid managed care population. This strength of the program supports DHS' progress in achieving the Iowa Medicaid Managed Care Quality Assurance System *Access to Care* goal of *improving network adequacy* and the Iowa PAHP Quality Strategy goal of *ensuring access to cost-effective healthcare through contract compliance by timely reviewing PAHP network adequacy reports.* Additionally, as demonstrated through the NAV activity, MCO members were accessing telehealth services, and PAHP members had access to a sufficient network of general dentists in rural areas.

Program Weaknesses

- **Quality**
  - *Diabetes Monitoring for People With Diabetes and Schizophrenia, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications,* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing* are two of the lower-performing HEDIS measures statewide. These low rates indicate that Iowa Medicaid managed care members receiving behavioral health treatment using antipsychotic medications are not always being screened or monitored properly. Screening for 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. This weakness of the program supports the need for continued focus on the Iowa Medicaid Managed Care Quality Assurance System *Access to Care* goal of *increasing access to primary care and specialty care* and the *Behavioral Health* goal of *promoting mental health through the Integrated Health Home Program*.
  - As demonstrated through lower performance for the *Breast Cancer Screening, Cervical Cancer Screening,* and *Chlamydia Screening in Women* HEDIS measures, many women enrolled in Iowa's Medicaid managed care program are not being seen or screened by their providers. Breast cancer is one of the most common cancers among American women, while cervical cancer is one of the most common causes of cancer death for American women. Effective screening and detection can improve outcomes, reduce the risk of death, and lower healthcare costs. Further, untreated chlamydia infections can lead to serious and irreversible complications such as pelvic inflammatory disease and infertility. Additionally, as indicated by lower program performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* HEDIS measures and the Effectiveness of Care CAHPS measures, Iowa Medicaid contracted providers have opportunities to spend additional time educating members on maintaining healthy lifestyle habits, including proper nutrition, physical activity, and smoking and tobacco cessation strategies. Additionally, Iowa Medicaid contracted providers may be ordering unnecessary imaging studies for members experiencing low back pain and inappropriately treating upper respiratory infections with antibiotics as indicated through the related, lower-performing HEDIS measure indicators. Unnecessary or routine imaging for low back pain is not associated with improved outcomes and exposes members to unnecessary harms such as radiation. Also, inappropriate use of antibiotics has led to the development of antibiotic resistant bacteria and is ineffective in treating viral upper respiratory infections. This weakness of the program supports the need for continued focus on the Iowa Medicaid Managed Care Quality Assurance System *Access to Care* goal of *increasing access to primary care and specialty care*.
  - Overall, the Iowa Medicaid managed care program demonstrated lower performance for *Comprehensive Diabetes Care* HEDIS measure indicators, indicating that some adult Iowa Medicaid managed care members are not receiving proper diabetes management to help control their blood

Program Weaknesses

glucose and reduce the risk of complications related to diabetes. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. This weakness of the program supports the need for continued focus on the Iowa Medicaid Managed Care Quality Assurance System *Access to Care* goal of *increasing access to primary care and specialty care*.

- **Timeliness**
  - Lower performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* HEDIS measure indicators demonstrates that Iowa Medicaid managed care enrolled women are experiencing barriers to accessing prenatal and postpartum care. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants. While DHS has mandated the *Timeliness of Postpartum Care* PIP, which is an overall strength for the program, the lower performance of these measure indicators demonstrates a need for continued focus on quality initiatives to increase member access to timely prenatal and postpartum care through the PIP activity and/or other activities implemented through the MCOs' quality assessment and performance improvement (QAPI) programs. While the initiation of the *Timeliness of Postpartum Care* PIP is an overall strength for the Iowa Medicaid managed care program, the lower performance of the *Prenatal and Postpartum Care* measure indicators supports the need for continued focus on the Iowa Medicaid Managed Care Quality Assurance System *Access to Care* goal of *improving timeliness of postpartum care* and the *Improving Coordinated Care* goal of *improving the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes*.
- **Access**
  - Although both adult and child members have access to dental benefits through the Iowa Medicaid managed care program and the PAHPs performed exceptionally well in the Availability of Services and Assurances of Adequate Capacity and Services compliance review standards, some members are not obtaining adequate dental care, as demonstrated through lower-performing PAHP performance measure rates. While the *Members Who Received Preventive Dental Care* measure rate remained relatively stable, the rates for *Members Who Accessed Dental Care* and *Members Who Received a Preventive Examination and a Follow-Up Examination* declined. Additionally, neither PAHP reached its PIP goal for accessing dental services, and the study indicator measurement rates (*Annual Dental Visits* [Delta Dental of Iowa] and *Increase the Percentage of Dental Services* [Managed Care of North America Dental]) demonstrated statistically significant declines over the established baseline measurement period. The COVID-19 pandemic may have been a contributing factor to the lower rates; however, the PAHPs' PIP interventions were either passive and incomplete, or were not revisited to include challenges associated with the pandemic. Further, as demonstrated through the PAHP NAV activity, approximately 85 percent of DWP Kids members with at least one fee-for-service (FFS) encounter likely experienced a disruption in dental care when transitioning from FFS to managed care, which may present a barrier to dental care. HSAG has determined that access to dental services is a weakness of the Iowa Medicaid managed care program over previous EQR years. This weakness of the program supports the need for enhanced focus on the Iowa PAHP Quality Strategy goals for *promoting appropriate utilization of services within acceptable standards of dental practice* and *ensuring access to cost-effective healthcare through contract compliance by incentivizing access to preventive dental services.*
  - As demonstrated through overall lower performance in the Access to Preventive Care and Living With Illness HEDIS domains, Iowa Medicaid managed care members are not always accessing preventive services or getting screened and treated for chronic conditions. Specifically, accessing primary or

Program Weaknesses
specialty care services is critical to addressing acute issues and managing chronic conditions and is important for members to receive counseling for nutrition and physical activity to reduce risk related to untreated obesity. This weakness of the program supports the need for continued focus on the Iowa Medicaid Managed Care Quality Assurance System *Access to Care* goal of *increasing access to primary care and specialty care*.

Program Recommendations	
Recommendation	**Associated Quality Strategy Goal to Target for Improvement**
• **Initiate Provider Collaborative—**DHS should collaborate with the MCOs to develop strategies to increase provider adherence to nationally recognized best practices and clinical practice guidelines. - DHS/MCOs should identify focused areas for improvement using information published in the *IA Health Link Managed Care Annual Performance Report*[1-4] and this EQR technical report to target specific areas to address with Iowa contracted network providers. Examples of areas that could be focused on include appropriate screenings for the physical health needs of members diagnosed with mental health conditions; treatment of low back pain and upper respiratory infections; and member counseling on healthy lifestyle habits, including proper nutrition, physical activity, and smoking and tobacco cessation strategies. - DHS/MCOs could consider information-gathering efforts with high-volume, contracted providers to obtain information about gaps in member care and/or ineffective treatment options to better understand the provider perspective on why Iowa Medicaid members are not getting recommended screenings, counseling on healthy lifestyle habits, and appropriate treatment for certain conditions (e.g., low back pain and dual diagnoses of mental health/chronic conditions). - DHS could require the MCOs to analyze data to identify whether there are any health	• **Goal: *Access to Care*** - Increase access to primary care and specialty care • **Goal: *Behavioral Health*** - Promote mental health through the Integrated Health Home Program - Identify common behavioral health conditions, use of community services, follow-up care, and medication adherence • **Goal: *Healthy Equity*** - Identify health disparities or inequities and target those areas for improvement

[1-4] Iowa Department of Human Services, Iowa Medicaid Enterprise. *IA Health Link Managed Care Annual Performance Report (July 2019– June 2020)*. Available at: https://www.legis.iowa.gov/docs/publications/DF/1207563.pdf. Accessed on: Oct 27, 2021.

Program Recommendations	
disparities or inequities in the areas of focus, and these data could be shared with the providers as part of the collaborative efforts. These disparities/inequities could include race, ethnicity, age, sex, member residence (urban versus rural), etc. - From the information gathered through the provider collaborations, DHS/MCOs could implement initiatives to reduce gaps in care and improve the quality of care. • **Develop Quality of Care Outcomes Goal—**DHS should update its Quality Strategy to include a clinical outcomes goal that focuses on reducing gaps in care and supports member/provider adherence to effective treatment protocols. - As part of this goal development, DHS should consider assigning minimum performance benchmarks to a DHS-defined set of performance measures that pertain to quality of care and member health outcomes. Setting minimum performance benchmarks should incentivize the MCOs to focus efforts on improving quality of care for their members. - DHS could consider whether an MCO pay-for-performance initiative would be an appropriate strategy to support program improvement in focused areas.	
• **Increase Telehealth Usage—**With NCQA specification updates to 40 HEDIS measures with new telehealth accommodations, DHS and the MCOs should develop initiatives to promote telehealth usage in older members and those living in rural areas, since those populations were identified as having lower usage. - DHS/MCOs should assess the barriers that prevent members from using telehealth services when telehealth is available. - After the barriers are identified, DHS and the MCOs should develop a collaborative to discuss appropriate strategies and interventions to implement program-wide to improve telehealth usage in older adults and for those members residing in rural locations. - DHS and the MCOs should evaluate whether telehealth usage is linked to improved performance measure rates and assess whether	• **Goal:** ***Access to Care*** - Improve network adequacy - Improve timeliness of postpartum care - Increase access to primary care and specialty care • **Goal:** ***Behavioral Health*** - Promote behavioral health by measuring follow-up after hospitalization/follow-up after emergency department visit (FUH/FUM) for pediatric and adult populations - Promote mental health through the Integrated Health Home Program - Identify common behavioral health conditions, use of community services, follow-up care, and medication adherence • **Goal:** ***Decrease Cost of Care***

Program Recommendations	
the implemented interventions or strategies for telehealth usage correlate to better health outcomes. • **Dental PIP Intervention Mandate—**The dental PAHPs have initiated preventive dental services PIPs; however, there were noted concerns with the interventions that had been implemented, and performance measure rates remained low and decreased since CY 2019. Additionally, the PIPs did not consider any potential disparities or inequities that contributed to this low performance. - DHS should require the PAHPs to analyze their performance measure data related to member access to preventive dental services to determine if there are any disparities or inequities that exist within the member population not accessing preventive dental care. - Upon identification of the disparity/inequity (e.g., race, ethnicity, age, geographical location of residence), DHS should require the PAHPs to develop actionable interventions to support improvement and eliminate the disparity/inequity. - DHS should further require the PAHPs to regularly assess their interventions to determine if the interventions are effective at mitigating the disparity. DHS should also require the PAHPs to provide regular intervention progress updates to keep DHS informed of any barriers the PAHPs encounter to performance improvement.	- Reduce the rate of potentially preventable readmissions and nonemergent ED visits • **Goal: *Improving Coordinated Care*** - Improve the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes • **Goal: *Healthy Equity*** - Identify health disparities or inequities and target those areas for improvement • **Goal: *Preventive Dental Services*** - Promote appropriate utilization of services within acceptable standards of dental practice - Incentivize access to preventive dental services - Promote healthcare quality standards in managed care programs by monitoring processes for improvement opportunities and assist PAHPs with the implementation of improvement strategies - Ensure data collection of race and ethnicity, as well as aid category, age, and gender in order to develop meaningful objectives for improvement in preventive and chronic dental care by focusing on specific populations - Promote the use and interoperability of health information technology between providers, PAHPs, and Medicaid

2. Overview of the Iowa Medicaid Program

Managed Care in Iowa

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

Overview of Managed Care Plans (MCPs)

During the CY 2021 review period, DHS 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	438,975	• 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	315,128		

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

[2-2] Iowa Department of Human Services, Iowa Medicaid Enterprise. *IA Health Link Managed Care Organization SFY 2021 Quarter 4 Performance Data*. September 2021. Available at: https://dhs.iowa.gov/sites/default/files/SFY21_Q4_Report.pdf?092420211504. Accessed on: Oct 7, 2021.

[2-3] Iowa Department of Human Services. *Comparison of the State of Iowa Medicaid Enterprise Basic Benefits Based on Eligibility Determination*. Rev. 09/21. Available at: https://dhs.iowa.gov/sites/default/files/Comm519.pdf?092720211503. Accessed on: Oct 7, 2021.

PAHPs	Total Enrollment[2-4]	Covered Services[2-5,2-6]	Service Area
DDIA	506,477	• 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	270,171		

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

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

MCP		Enrollment Population	Enrollment Count	Total Enrollment
MCOs	AGP	Medicaid	389,316	754,103
		Hawki	49,659	
		Total	**438,975**	
	ITC	Medicaid	291,316	
		Hawki	23,812	
		Total	**315,128**	

2-4 PAHP enrollment numbers (as of October 5, 2021) provided to HSAG by DHS.

2-5 Iowa Department of Human Services. *Dental Wellness Plan Benefits*. Available at: https://dhs.iowa.gov/dental-wellness-plan/benefits. Accessed on: Oct 7, 2021.

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

2-7 Iowa Department of Human Services, Iowa Medicaid Enterprise. *IA Health Link Managed Care Organization SFY 2021 Quarter 4 Performance Data*. September 2021. Available at: https://dhs.iowa.gov/sites/default/files/SFY21_Q4_Report.pdf?092420211504. Accessed on: Oct 7, 2021.

2-8 PAHP enrollment numbers (as of October 5, 2021) provided to HSAG by DHS.

MCP		Enrollment Population	Enrollment Count	Total Enrollment
PAHPs	DDIA	DWP Adults	260,858	776,648
		DWP Kids	181,607	
		Hawki	64,012	
		Total	**506,477**	
	MCNA	DWP Adults	150,180	
		DWP Kids	119,991	
		Hawki	NA*	
		Total	**270,171**	

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

Quality Strategy

The Iowa Medicaid Managed Care Quality Assurance System (Quality Strategy)[2-9,2-10] outlines DHS' strategy for assessing and improving the quality of managed care services offered by its contracted MCOs and PAHPs using a triple aim framework. The triple aim goal is to improve outcomes, improve patient experience, and ensure that Medicaid programs are financially sustainable. Table 2-3 and Table 2-4 present the Iowa Medicaid Managed Care Quality Assurance System goals for the MCOs and PAHPs, respectively.

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

Quality Strategy Goals
Behavioral Health
• Promote behavioral health by measuring follow-up after hospitalization/follow-up after emergency department visit (FUH/FUM) for pediatric and adult populations. The LTSS population, including Health Home members, will be stratified.

[2-9] Iowa Department of Human Services Iowa Medicaid Enterprise. *Iowa Medicaid Managed Care Quality Assurance System*: 2021. Available at: https://dhs.iowa.gov/sites/default/files/2021_Iowa_Managed_Care_Quality_Plan.pdf?070120211527. Accessed on: Sep 27, 2021.

[2-10] Iowa Department of Human Services Iowa Medicaid Enterprise. *Iowa Medicaid Dental Pre-Ambulatory Health Plan Quality Assurance System*: *2019*. Available at: https://dhs.iowa.gov/sites/default/files/2019%20Dental%20PAHP%20Quality%20Strategy.pdf?060520191449. Accessed on: Sep 27, 2021. Of note, the *Iowa Medicaid Dental Pre-Ambulatory Health Plan Quality Assurance System*: *2019* is currently under revision.

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

Quality Strategy Goals
Health Equity
• Identify health disparities or inequities and target those areas for improvement. • Monitor the implementation and progress of the Health Equity Plans.
Voice of the Customer
• Annually, review the CAHPS results and make recommendations for improvement. • Quarterly, review the Home and Community-Based Services (HCBS) Iowa Participant Experience Survey (IPES) results and make recommendations for improvement. • Quarterly, review the appeals and grievance reports and make recommendations for improvement.

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

Quality Strategy Goals
• Promote appropriate utilization of services within acceptable standards of dental practice.
• Ensure access to cost-effective healthcare through contract compliance by: – Timely review of PAHP network adequacy reports. – Incentivizing access to preventive dental services.
• Comply with State and federal regulatory requirements through the development and monitoring of quality improvement (QI) policies and procedures by: – Annually reviewing and providing feedback on PAHP quality strategies. – Quarterly reviewing PAHP quality meeting minutes.
• Dental costs are reduced while quality is improved by: – Encouraging member engagement in dental care through completion of oral HRAs and a tiered benefit structure that expands benefits for members receiving preventive services
• Provide care coordination to members based on HRAs by: – Monitoring HRA completion for members continuously enrolled for six months.
• Ensure that transitions of care do not have adverse effects by: – Maintaining historical utilization file transfers between DHS and the PAHPs, including the information needed to effectively transfer members.
• Promote healthcare quality standards in managed care programs by monitoring processes for improvement opportunities and assist PAHPs with implementation of improvement strategies through: – Regularly monitoring health outcomes measure performance.
• Ensure data collection related to race and ethnicity, as well as aid category, age, and gender in order to develop meaningful objectives for improvement in preventive and chronic dental care by focusing on specific populations. The income maintenance worker collects race and ethnicity as reported by the individual on a voluntary basis during the eligibility process.
• Promote the use and interoperability of health information technology between providers, PAHPs, and Medicaid.

Quality Initiatives

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

DWP Kids Transition—Effective July 1, 2021, DHS transitioned the administration of children's Medicaid dental benefits from a FFS program to a managed care program, referred to as the Dental Wellness Plan (DWP) Kids program. These members were enrolled in one of the two dental PAHPs currently contracted with DHS. Members were able to switch dental carriers for any reason through September 30, 2021. Additionally, to ensure continuity of care during the initial 90-day transition period, any Medicaid FFS nonexpired prior authorization was required to be honored through September 30, 2021. Additionally, claims submitted to the PAHPs from a nonnetwork provider were required to be honored (if medical necessity was met) by the dental plans through September 30, 2021. Under FFS, the children's Medicaid dental benefit was coordinated through a partnership between DHS and the Iowa Department of Public Health (IDPH) to develop the I-Smile program. I-Smile is administered through contracts with local public health organizations to help families access dental services, prevent dental disease, and better understand the importance of good oral health. The existing infrastructure of the I-Smile program continued with this transition and remains an integral part of the DWP Kids program. More information on the I-Smile program can be located on its website, http://ismile.idph.iowa.gov/.

Health Equity Plan/P4P: As one of the SFY 2022 MCP Pay For Performance (P4P) measures, the IME Quality Committee required each medical MCP to develop a Health Equity Plan to cover a three-year time frame (July 1, 2022–June 30, 2025). Areas of focus in these plans include diabetes, asthma, maternal child health, mental health and substance abuse disorders, COVID-19, and community integration. In CY 2021, draft plans were reviewed by the Quality Committee for inclusion of 10 required components, such as strategic goals, data streams, clear measures of success, and ongoing reviews for progress. The Quality Committee then provided each plan with recommendations and required improvements to be implemented in order to finalize their plans. Finalization and implementation of each plan will take place in CY 2022.

1915(i) State Plan HCBS Habilitation: In CY 2021, a stakeholder workgroup convened to:

- Identify a functional assessment tool for 1915(i) HCBS Habilitation program needs-based eligibility determination that derives an acuity score.
- Review and amend the risk-based and needs-based criteria for 1915(i) HCBS Habilitation program eligibility to more clearly define the eligible population.
- Review the Home-Based Habilitation Tiers to align with the newly identified functional assessment tool acuity scoring.
- Add training requirements for providers of Home-Based Habilitation services.
- Add to Supported Employment services the Individual Placement and Support (IPS) Supported Employment Evidenced-Based Practice Model.

This work resulted in amending the 1915(i) State Plan Amendment (SPA) and amending the Habilitation administrative rules to align with the SPA.

3. Assessment of Managed Care Organization (MCO) Performance

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2021 review period to evaluate the performance of MCOs on providing quality, timely, and accessible healthcare services to Iowa Medicaid managed care members. Quality, as it pertains to EQR, means the degree to which the MCOs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to DHS' network adequacy standards) and §438.206 (adherence to DHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the MCOs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in CY 2021 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, refer to Appendix A.

Validation of Performance Improvement Projects

For the CY 2021 validation, the MCOs continued two DHS-mandated PIP topics, *Timeliness of Postpartum Care* and *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*, reporting the Design and Implementation stages for the performance indicators to be collected. 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 Iowa CAHPS child survey Question #45 (DHS Question #50): The Customer Service at a Child's Health Plan gave information or help needed, with a response of Usually or Always.
ITC	*Timeliness of Postpartum Care*	The percentage of women who delivered a live birth on or between October 8th of the year prior to the measurement year and October 7th of the measurement year who had a postpartum care visit on or between 7 and 84 days after delivery.
	CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	CAHPS Measure: Customer 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 Iowa for state fiscal year (SFY) 2020 (July 1, 2019–June 30, 2020), and SFY 2021 (July 1, 2020–June 30, 2021). HSAG also completed PMV activities for Iowa Total Care for SFY 2021 (July 1, 2020–June 30, 2021). Amerigroup Iowa underwent PMV for two SFYs since it had not completed all PMV-associated tasks for the SFY 2020 performance measures.[3-1] By conducting PMV of Amerigroup Iowa for two SFYs during a single year, HSAG ensured that Amerigroup Iowa and Iowa Total Care will be prepared to participate in a future PMV of SFY 2022 performance measures since both MCOs have completed PMV through SFY 2021.

[3-1] HSAG postponed the review of Amerigroup Iowa's CY 2020 PMV activity at Amerigroup Iowa's request, and with DHS approval, to provide Amerigroup Iowa additional time to manually abstract its care plan performance data.

Table 3-2 shows the list of performance measures and measurement periods from both SFY 2020 and 2021.

Table 3-2—Performance Measures for Validation

2020 and 2021 Performance Measures Selected by DHS for Validation[3-2]				
Measure Name and Description	**MCO**	**Measurement Period**	**Method**	**Steward**
Receipt of Authorized Services The percentage of eligible members who received authorized home- and community-based services (HCBS) documented in the person-centered care plan from the care plan's effective date through the service authorization end date and/or care plan end date.	AGP	July 1, 2019–June 30, 2020	Hybrid	DHS
	AGP and ITC	July 1, 2020–June 30, 2021		
Receipt of Authorized One-Time Services The percentage of eligible members who received authorized, one-time HCBS in the person-centered care plan from the care plan's effective date through the service authorization end date and/or care plan end date.	AGP	July 1, 2019–June 30, 2020	Hybrid	DHS
	AGP and ITC	July 1, 2020–June 30, 2021		
Provision of Care Plan The percentage of eligible members whose care plan was provided to all participants in the member's care team.	AGP	July 1, 2019–June 30, 2020	Hybrid	DHS
	AGP and ITC	July 1, 2020–June 30, 2021		
Person-Centered Care Plan (PCCP) Meeting The percentage of eligible members who participated in planning and agreed to the time and/or location of the PCCP meeting.	AGP	July 1, 2019–June 30, 2020	Hybrid	DHS
	AGP and ITC	July 1, 2020–June 30, 2021		
Care Team Lead Chosen by the Member The percentage of eligible members who chose his or her own care team lead.	AGP	July 1, 2019–June 30, 2020	Hybrid	DHS
	AGP and ITC	July 1, 2020–June 30, 2021		

[3-2] There were technical specification changes in the performance measures from CY 2019 to CY 2020; therefore, AGP's CY 2020 rates are presented to align with these changes.

2020 and 2021 Performance Measures Selected by DHS for Validation[3-2]				
Measure Name and Description	**MCO**	**Measurement Period**	**Method**	**Steward**
Member Choice of Home and Community-Based Services (HCBS) Settings The percentage of eligible members whose care plan documents member choice and/or placement in alternative HCBS settings.	AGP	July 1, 2018–June 30, 2019	Hybrid	DHS
	AGP and ITC	July 1, 2019–June 30, 2020		

DHS required each MCO to contract with an NCQA-certified HEDIS licensed organization to undergo a full audit of its HEDIS reporting process. As Iowa Total Care joined the Iowa Medicaid program in July 2019, only HEDIS MY 2020 data were available.

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

Table 3-3—HEDIS Measures

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

HEDIS Measure
Living With Illness
Comprehensive Diabetes Care
Hemoglobin A1c (HbA1c) Testing
HbA1c Control (<8.0%)
HbA1c Poor Control (>9.0%)
Blood Pressure Control (<140/90 mm Hg)
Eye Exam (Retinal) Performed
Controlling High Blood Pressure
Statin Therapy for Patients With Cardiovascular Disease
Received Statin Therapy—Total
Statin Therapy for Patients With Diabetes
Received Statin Therapy
Behavioral Health
Diabetes Monitoring for People With Diabetes and Schizophrenia
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Follow-Up After ED Visit for Mental Illness
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Initiation and Engagement of AOD Abuse or Dependence Treatment
Initiation of AOD Treatment—Total
Engagement of AOD Treatment—Total
Metabolic Monitoring for Children and Adolescents on Antipsychotics
Blood Glucose and Cholesterol Testing—Total
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total
Keeping Kids Healthy
Child and Adolescent Well-Care Visits—Total
Childhood Immunization Status
Combination 3

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

Compliance Review

CY 2021 commenced a new three-year cycle of compliance reviews. The compliance reviews for the DHS-contracted MCOs comprise 14 program areas, referred to as standards, that correlate to the federal standards and requirements identified in 42 CFR §438.358(b)(1)(iii). These standards also include applicable State-specific contract requirements and areas of focus identified by DHS. For CY 2021, HSAG conducted a review of seven standards as identified in Table 3-4 under Year One. Table 3-4 also delineates the compliance review activities, and standards reviewed, in year two and year three of the three-year cycle.

Table 3-4—Compliance Review Standards

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

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

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

Network Adequacy Validation

The CY 2021 NAV activity included a telehealth analysis of MCO members who used telehealth services during CY 2020. The analysis evaluated the following dimensions of telehealth utilization:

- Percentage of members using telehealth services. This dimension calculated the percentage of members who received one or more telehealth services during CY 2020.
- Use of telehealth services by member demographics. This dimension evaluated the age, race, and sex of members who received one or more telehealth services during CY 2020.
- Use of telehealth services by member geography. This dimension evaluated the geographic location (i.e., urban or rural) of members who received one or more telehealth services during CY 2020.
- Use of telehealth services by members with chronic conditions compared to members without chronic conditions. This dimension examined the use of telehealth services by members who have chronic conditions compared to members who do not have chronic conditions.

Encounter Data Validation

In CY 2021, HSAG conducted and completed the CY 2020 and CY 2021 EDV activities for the two MCOs. The EDV activities included:

- Information systems (IS) review—assessment of DHS' and/or the MCOs' information systems and processes.
- Administrative profile—analysis of DHS' electronic encounter data completeness, accuracy, and timeliness.
- Comparative analysis—analysis of DHS' electronic encounter data completeness and accuracy through a comparative analysis between DHS' electronic encounter data and the data extracted from the MCOs' data systems.
- Technical assistance—follow-up assistance provided to the MCOs that perform poorly in the comparative analysis.
- Medical record review (MRR)—analysis of DHS' electronic encounter data completeness and accuracy through a comparison between DHS' electronic encounter data and the information documented in the corresponding members' medical records.

For Amerigroup Iowa, HSAG had previously conducted the core EDV activities listed above, except for MRR. Since 2019 was the first year that Iowa Total Care submitted encounter data to DHS, HSAG conducted an IS review with Iowa Total Care in CY 2019. As such, for CY 2020 and CY 2021, HSAG conducted the core evaluation activities according to Table 3-5 for each of the respective MCOs.

Table 3-5—Core Evaluation Activities for CY 2020 and CY 2021 for each MCO

Calendar Year	MCO	Core Activity	Study Review Period*
CY 2020	AGP	MRR	January 1, 2019–December 31, 2019
	ITC	Administrative Profile Analysis	July 1, 2019–December 31, 2019
CY 2021	AGP	Comparative Analysis/Technical Assistance	January 1, 2019–June 30, 2020
	ITC		July 1, 2019–June 30, 2020

* Study review period refers to the encounter dates of service to be evaluated.

Consumer Assessment of Healthcare Providers and Systems Analysis

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The MCOs were responsible for obtaining CAHPS vendors to administer the CAHPS surveys on the MCOs' behalf. HSAG presents top-box scores, which indicate the percentage of members who responded to the survey with positive experiences in a particular aspect of their healthcare. Table 3-6 displays the various measures of member experience.

Table 3-6—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
Effectiveness of Care
Advising Smokers and Tobacco Users to Quit
Discussing Cessation Medications
Discussing Cessation Strategies
CCC Composite Measures/Items
Access to Specialized Services
Family Centered Care (FCC): Personal Doctor Who Knows Child

CAHPS Measures
Coordination of Care for Children With Chronic Conditions
Access to Prescription Medicines
FCC: Getting Needed Information

Quality Rating

HSAG analyzed MY 2020 HEDIS results and MY 2020 CAHPS data from the two MCOs, for presentation in the 2021 Iowa Health Link MCO Scorecard. MCO performance was evaluated in the following six reporting categories identified as important to consumers:

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

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

EQR Activity Results

Amerigroup Iowa

Validation of Performance Improvement Projects

Performance Results

Table 3-7 displays the overall validation status and baseline results for each PIP topic.

Table 3-7—Overall Validation Rating for AGP

PIP Topic	Validation Rating	Study Indicator	Study Indicator Results		
			Baseline	R1	R2
Timeliness of Postpartum Care	*Met*	The percentage of women who delivered a live birth on or between October 8th of the year prior to the measurement year and October 7th of the measurement year who had a postpartum care visit on or between 7 and 84 days after delivery.	68.9%		
CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	*Met*	The percentage of members who answer Amerigroup Iowa CAHPS child survey Question #45 (DHS Question #50): The Customer Service at a Child's Health Plan gave information or help needed, with a response of Usually or Always?	84.3%		

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

Table 3-8 displays the interventions implemented to address the barriers identified by Amerigroup Iowa using QI and causal/barrier analysis processes for each PIP topic.

Table 3-8—Interventions for AGP

Intervention Descriptions	
Timeliness of Postpartum Care	***CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed***
Conducted telephonic outreach to members providing education on the importance of postpartum care and assisted members with scheduling their appointments.	Conducted post-call survey audits of customer service representatives and provided coaching, feedback, and additional training as needed.
Educated providers in a Provider Quality Incentive Program on the missed opportunity report which identifies their assigned members and encouraged providers to outreach members to complete their postpartum visit.	A lead staff was identified to monitor and ensure that information in its Knowledge Management system, used by national call center representatives as a source of truth to answer member questions, is correct and up to date.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Amerigroup Iowa developed methodologically sound PIPs, documenting appropriate data collection methods for generating and reporting the indicator outcomes. [**Quality** and **Timeliness**]

Strength #2: Amerigroup Iowa conducted appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement within its current processes. [**Quality**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for Amerigroup Iowa.

Why the weakness exists: No weaknesses were identified; therefore, this section is not applicable.

Recommendation: No significant weaknesses were identified; therefore, this section is not applicable.

Performance Measure Validation

Performance Results—SFY 2020

HSAG reviewed Amerigroup Iowa's eligibility and enrollment data, claims and encounters, case management systems, plan of care process, and data integration process, which included live demonstrations of each system. Overall, Amerigroup Iowa demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with Amerigroup Iowa's processes. Additionally, HSAG did not identify any issues during the primary source verification (PSV) interview session, which included a focus on member-specific enrollment, claims, and case management data to support performance measures #1, 2, 3, 4, 5, and 6.

Table 3-9, Table 3-10, Table 3-11, and Table 3-12 show measure designation and reportable measure rates for SFY 2020. While individual rates were produced for each of the eight waiver populations, only the aggregate rate is displayed. Amerigroup Iowa received a measure designation of *Reportable (R)* for all performance measures included in the PMV activity.

Table 3-9—SFY 2020 #1a Performance Measure Designation and Rates for AGP*

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

* Rates are provided for information only.

Table 3-10—SFY 2020 #1b Performance Measure Designation and Rates for AGP*

Performance Measure		Measure Designation	SFY 2020 Measure Rate
1b	*The Percentage of Eligible Members For Whom 100 Percent of HCBS Documented in Members' Care Plans Had a Corresponding Approved Service Authorization*	*R*	81.26%

* Rates are provided for information only.

Table 3-11—SFY 2020 #2 Performance Measure Designation and Rates for AGP*

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

* Rates are provided for information only.

Table 3-12—SFY 2020 #3, #4, #5, and #6 Performance Measure Designation and Rates for AGP

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

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

Strengths, Weaknesses, and Recommendations—SFY 2020

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: Amerigroup Iowa deployed a comprehensive approach to ensuring the health and safety of its LTSS members throughout the COVID-19 public health emergency and natural disasters experienced in 2020. Amerigroup Iowa adeptly used the resources at its disposal to authorize services that were more widely available for members in home environments while still finding ways to maintain flexibility so that preferred services could be accessed easily when they became available. Amerigroup Iowa closely monitored utilization to ensure that members were able to access services and made necessary adjustments due to limited service availability in certain areas. [**Access**]

Weaknesses and Recommendations

Weakness #1: Amerigroup Iowa relied on manual abstraction of care coordination and service plan records for measures #3 through #6, which introduces risk for human error, potentially impacting reporting. [**Quality**]

Why the weakness exists: Amerigroup Iowa's care coordination system, Health Innovations Platform (HIP), housed service plan and contact data in portable document format (PDF) forms that did not allow reportable fields.

Recommendation: Although Amerigroup Iowa indicated that it had standardized the manual review process including the implementation of training and quality assurance efforts and was not moving toward automation, HSAG continues to recommend that Amerigroup Iowa consider initiating an information technology (IT) project to create reportable fields within the HIP platform service plan and contact forms and provide its analytics team with back-end access to the platform to extract the data using structured query language (SQL) code as used for measures #1 and #2. This investment of IT resources would create savings over the long term through preserving clinical staff time for clinical activities. It would also allow for future capabilities to report the data administratively should the MCO technical specifications be adjusted to include administrative reporting.

Performance Results—SFY 2021

HSAG reviewed Amerigroup Iowa's eligibility and enrollment data, claims and encounters, case management systems, plan of care process, and data integration process, which included live demonstrations of each system. Overall, Amerigroup Iowa demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with Amerigroup Iowa's processes. Additionally, HSAG did not identify any issues during the PSV interview session, which included a focus on member-specific enrollment, claims, and case management data to support performance measures #1, 2, 3, 4, 5, and 6.

Table 3-13, Table 3-14, Table 3-15, and Table 3-16 show measure designation and reportable measure rates for SFY 2020. While individual rates are produced for each of the eight waiver populations, only the aggregate rate is displayed. Amerigroup Iowa received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 3-13—SFY 2021 #1a Performance Measure Designation and Rates for AGP*

Performance Measure		Measure Designation	Measure Rate				
			0%	1–49%	50–74%	75–89%	90–100%
1a	*Percentage of Eligible Members With Applicable Percentage of Authorized Services Utilized*	*R*	12.02%	42.43%	22.53%	10.78%	12.23%

* Rates are provided for information only.

Table 3-14—SFY 2021 #1b Performance Measure Designation and Rates for AGP*

Performance Measure		Measure Designation	SFY 2021 Measure Rate
1b	*The Percentage of Eligible Members For Whom 100 Percent of HCBS Documented in Members' Care Plans Had a Corresponding Approved Service Authorization*	*R*	79.61%

* Rates are provided for information only.

Table 3-15—SFY 2021 #2 Performance Measure Designation and Rates for AGP*

Performance Measure		Measure Designation	SFY 2021 Results		
			Denominator	Numerator	Rate
2a	*Members With One or More Documented Care Plan One-Time Service*	*R*	1,447	33	2.28%
2b	*Members With Documented Care Plan One-Time Service With Corresponding Approved Service Authorization*	*R*	33	12	36.36%
2c	*Percentage of Authorized One-Time Services Utilized*	*R*	17	10	58.82%

* Rates are provided for information only.

Table 3-16—SFY 2021 #3, #4, #5, and #6 Performance Measure Designation and Rates for AGP

Performance Measure		Measure Designation	SFY 2021 Results		
			Denominator	Numerator	Rate
3	*Provision of Care Plan*	*R*	1,664	746	44.83%
4	*Person-Centered Care Plan Meeting**	*R*	1,664	1,176	70.67%
5	*Care Team Lead Chosen by the Member*	*R*	1,664	1,203	72.30%
6	*Member Choice of HCBS Settings*	*R*	1,664	1,593	95.73%

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

Strengths, Weaknesses, and Recommendations—SFY 2021

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: Amerigroup Iowa initiated a feedback loop with front-line LTSS and integrated health home (IHH) staff members for testing care coordination system, process, or reporting enhancements, as well as testing documentation enhancements. Amerigroup Iowa has been able to target solutions that have created the most efficiencies for clinical staff members with data collection by reviewing staff feedback about process challenges and employing staff members in the development and testing of enhancements. As a result, Amerigroup Iowa is realizing improved data collection and audit scores, which support the accuracy of reporting performance measures. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Amerigroup Iowa continued to rely on manual abstraction of care coordination and service plan records for measures #3 through #6, which introduces risk for human error. [**Quality**]

Why the weakness exists: Amerigroup Iowa's care coordination system, HIP, housed service plan and contact data in PDF forms that did not allow reportable fields.

Recommendation: Although Amerigroup Iowa indicated that it had standardized the manual review process including the implementation of training and quality assurance efforts and was not moving toward automation, HSAG continues to recommend that Amerigroup Iowa 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 SQL code as used for measures #1 and #2. This investment of IT resources would create savings over the long term through preserving clinical staff time for clinical activities. It would also allow for future capabilities to report the data administratively should the MCO technical specifications be adjusted to include administrative reporting.

Performance Results—HEDIS

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

Table 3-17—HEDIS MY 2020 Results for AGP

Measures	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	Three-Year Trend	HEDIS MY 2020 Star Rating
Access to Preventive Care					
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	84.86%	84.13%	80.59%	↓	★★★
45–64 Years	90.88%	88.97%	85.27%	↓	★★
65 Years and Older	89.01%	90.43%	78.06%	↓	★
Use of Imaging Studies for Low Back Pain					
Use of Imaging Studies for Low Back Pain	70.19%	71.72%	70.97%	↑	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents^					
BMI Percentile Documentation—Total	78.83%	78.83%	72.02%	↓±	★★
Counseling for Nutrition—Total	65.45%	65.45%	65.69%	↑	★★
Counseling for Physical Activity—Total	62.77%	62.77%	61.07%	↓	★★
Women's Health					
Breast Cancer Screening					
Breast Cancer Screening	45.38%	55.96%	53.59%	↑ ±	★★
Cervical Cancer Screening^					
Cervical Cancer Screening	63.02%	63.02%	60.10%	↓ ±	★★
Chlamydia Screening in Women					
Total	47.44%	48.50%	44.86%	↓	★
Non-Recommended Cervical Cancer Screening in Adolescent Females					
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.26%	0.28%	0.21%	↑	★★★★

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

Measures	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	Three-Year Trend	HEDIS MY 2020 Star Rating
Prenatal and Postpartum Care^					
Timeliness of Prenatal Care	—	86.60%	78.10%	—	★
Postpartum Care	—	62.63%	68.86%	—	★
Living With Illness					
Comprehensive Diabetes Care^					
HbA1c Testing	91.48%	91.48%	89.54%	↓	★★★
HbA1c Control (<8.0%)	59.85%	59.85%	46.47%	↓	★★
*HbA1c Poor Control (>9.0%)**	27.98%	27.98%	42.34%	↓	★★
Blood Pressure Control (<140/90 mm Hg)	—	—	72.26%	—	NC
Eye Exam (Retinal) Performed	61.31%	61.31%	55.47%	↓	★★
Controlling High Blood Pressure^					
Controlling High Blood Pressure	—	—	65.69%	—	NC
Statin Therapy for Patients With Cardiovascular Disease					
Received Statin Therapy—Total	46.15%	72.07%	81.21%	↑ ±	★★★
Statin Therapy for Patients With Diabetes					
Received Statin Therapy	41.80%	62.20%	68.81%	↑ ±	★★★★
Behavioral Health					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	44.80%	67.17%	70.55%	↑	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.59%	77.62%	74.63%	↓	★
Follow-Up After ED Visit for AOD Abuse or Dependence					
7 Day Follow-Up—Total	44.04%	48.88%	46.06%	↑ ±	★★★★★
30 Day Follow-Up—Total	50.55%	55.19%	53.41%	↑ ±	★★★★★
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—Total	59.11%	67.82%	64.60%	↑ ±	★★★★
30-Day Follow-Up—Total	73.57%	77.51%	75.90%	↑ ±	★★★★★
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	41.57%	47.54%	48.83%	↑ ±	★★★★
30-Day Follow-Up—Total	65.69%	69.03%	69.37%	↑ ±	★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment					
Initiation of AOD Treatment—Total	70.94%	74.22%	69.95%	↓ ±	★★★★★
Engagement of AOD Treatment—Total	26.06%	29.04%	26.21%	↑ ±	★★★★★

Measures	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	Three-Year Trend	HEDIS MY 2020 Star Rating
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose and Cholesterol Testing–Total	28.26%	27.35%	23.12%	↓	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	63.95%	66.79%	58.96%	↓ ±	★★
Keeping Kids Healthy					
Childhood Immunization Status^					
Combination 3	76.89%	76.89%	75.43%	↓	★★★★
Combination 10	46.47%	46.47%	51.58%	↑	★★★★
Immunizations for Adolescents^					
Combination 1	87.83%	87.83%	88.81%	↑	★★★★
Combination 2	37.47%	37.47%	31.39%	↓	★★
Lead Screening in Children^					
Lead Screening in Children	81.02%	81.02%	82.00%	↑	★★★★
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%	—	NC
Well-Child Visits for Age 15 Months-30 Months—Two or More Well-Child Visits	—	—	70.09%	—	NC
Child and Adolescent Well-Care Visits					
Total	—	—	45.54%	—	NC
Medication Management					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	62.76%	65.27%	67.62%	↑	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	52.31%	51.71%	52.94%	↑	★★
Effective Continuation Phase Treatment	35.33%	35.77%	37.41%	↑	★★
Appropriate Testing for Pharyngitis					
Total	—	81.34%	80.59%	—	★★★
Appropriate Treatment for Upper Respiratory Infection					
Total	—	84.16%	85.99%	—	★★
Asthma Medication Ratio					
Total	61.10%	60.64%	66.94%	↑	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Total	—	43.43%	47.06%	—	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	36.20%	41.65%	42.87%	↑ ±	★★

Measures	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	Three-Year Trend	HEDIS MY 2020 Star Rating
Continuation and Maintenance Phase	40.93%	51.02%	45.50%	↑ ±	★
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	80.45%	86.67%	78.28%	↓	★★
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	38.96%	59.27%	74.41%	↑	★★★
Bronchodilator	45.54%	69.47%	83.39%	↑	★★
Statin Therapy for Patients With Cardiovascular Disease					
Statin Adherence 80%—Total	65.56%	68.66%	72.84%	↑ ±	★★★
Statin Therapy for Patients With Diabetes					
Statin Adherence 80%	63.37%	65.14%	70.34%	↑±	★★★★
Use of Opioids at High Dosage*					
Use of Opioids at High Dosage	—	3.16%	2.64%	—	★★★★
Use of Opioids From Multiple Providers*					
Multiple Prescribers	22.74%	20.67%	16.59%	↑ ±	★★★
Multiple Pharmacies	3.24%	3.06%	1.40%	↑ ±	★★★★★
Multiple Prescribers and Multiple Pharmacies	2.08%	2.11%	1.04%	↑ ±	★★★★

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

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

NC Indicates that a comparison is not appropriate, or the prior year's rate was unavailable.

^ In alignment with DHS and NCQA guidance, HEDIS 2020 (MY 2019) results for this measure were rotated with the HEDIS 2019 (MY 2018) hybrid rate.

± Due to changes in the technical specifications for this measure, exercise caution when trending rates.

↓ Indicates performance improved over a three-year time period

↑ Indicates performance improved over a three-year time period

HEDIS MY 2020 star ratings represent the following percentile comparisons:

★★★★★ = At or above the 90th percentile
★★★★= At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Strengths, Weaknesses, and Recommendations—SFY 2021

Through the EQR, HSAG assessed the performance for the HEDIS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within HEDIS performance 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: Amerigroup Iowa's performance under the Keeping Kids Healthy domain ranked between the 75th and 89th percentiles for the *Childhood Immunization Status—Combination 3* and *Combination 10* indicators, *Immunizations for Adolescents—Combination 1* indicator, and *Lead Screening in Children* indicator, indicating that members 0 to 2 years of age and 13 years of age received recommended immunizations and were screened by their providers. Additionally, Amerigroup Iowa has demonstrated a positive three-year trend for the *Childhood Immunization Status—Combination 10* indicator, *Immunizations for Adolescents—Combination 1* indicator, and *Lead Screening in Children* indicator in the midst of a national decline in childhood immunization rates due to the COVID-19 pandemic. [**Timeliness** and **Access**]

Strength #2: Amerigroup Iowa's performance under the Behavioral Health domain ranked at or above the 90th percentile for five of the 12 indicators: *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up* and *30-Day Follow-Up*, *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* and *Engagement of AOD Treatment*, and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*. Additionally, Amerigroup Iowa's performance ranked between the 75th and 89th percentiles for *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up* and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*. The rates for these indicators show that Amerigroup Iowa was engaged in providing follow-up treatment services to improve physical and mental function and reduce repeat ED visits, hospital readmissions, and healthcare spending. Additionally, due to the addition of telehealth services to the MY 2020 measure specifications, achieving rates on these indicators at or above the 75th percentile likely indicates a high adoption rate for telehealth services during the COVID-19 pandemic. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Amerigroup Iowa's performance under the Medication Management domain ranked at or above the 90th percentile for the *Use of Opioids From Multiple Providers—Multiple Pharmacies* indicator and ranked between the 75th and 89th percentiles for the *Use of Opioids at High Dosage* indicator. The rates for these indicators show that Amerigroup Iowa was engaged in working with providers to limit access to habit-forming medications when not medically necessary. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Amerigroup Iowa's performance under the Women's Health domain ranked below the 25th percentile for the *Chlamydia Screening in Women* and *Prenatal and Postpartum Care—Timeliness of Prenatal* and *Postpartum Care* indicators, 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. Additionally, timely and adequate prenatal and postpartum care can promote the long-term health and wellbeing of new mothers and their infants. [**Quality**, **Timeliness** and **Access**]

Why the weakness exists: The low rate for *Chlamydia Screening in Women* suggests that barriers exist for sexually active women between 16 and 24 years of age to access this important health screening, and the COVID-19 pandemic may have increased these barriers. Additionally, the low

Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care* indicator rates suggest women were experiencing barriers to accessing providers for prenatal and postpartum care.

Recommendation: HSAG recommends that Amerigroup Iowa partner with primary care and obstetrics and gynecology (OB-GYN) providers to conduct a focused study to determine why some female members 16 to 24 years of age who identified as sexually active were not getting screened for chlamydia to reduce the potential for serious and irreversible complications such as pelvic inflammatory disease and infertility. In addition, HSAG recommends that Amerigroup Iowa conduct a focused study that examines rates of prenatal and postpartum care across different geographic regions and different racial/ethnic groups to determine why some female members were not receiving timely prenatal or postpartum care and whether any health disparities might be impacting the rates at which women access healthcare during pregnancy. Upon identification of a root cause, Amerigroup Iowa should implement appropriate interventions (e.g., promotion of telehealth services, member incentives, provider education, and/or partnerships) to improve low performance rates within the Women's Health domain.

Weakness #2: Amerigroup Iowa's performance under the Behavioral Health domain ranked below the 25th percentile for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing*. These low rates indicate that patients receiving behavioral health treatment using antipsychotic medication were not always being screened or monitored properly. Screening for the physical health needs of members diagnosed with mental health conditions is an important way to improve overall health, quality of life, and economic outcomes. Additionally, monitoring of blood glucose and cholesterol testing are important components of ensuring appropriate management of children and adolescents on antipsychotic medications. [**Quality**]

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

Recommendation: HSAG recommends that Amerigroup Iowa partner with providers such as community mental health centers that treat the severe and persistently mentally ill (SPMI) population to conduct a root cause analysis or focused study to determine why members with severe mental illnesses are not being screened for diabetes or monitored for metabolic functioning. Upon identification of a root cause, Amerigroup Iowa should work with providers to implement appropriate interventions (e.g., process improvements, patient education campaigns, provider incentives) to improve the performance rates of these measures.

Weakness #3: Amerigroup Iowa's performance under the Medication Management domain ranked below the 25th percentile for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, indicating that some members were not receiving appropriate monitoring by their prescriber after initiation of ADHD medication. When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness, and inability to sustain

concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a physician with prescribing authority. [**Quality**]

Why the weakness exists: The low rates for the Medication Management measures suggest that barriers exist for members specifically related to appropriate medication management. This could be related to the overall decline in accessing routine medical care observed nationally due to the COVID-19 pandemic.

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

Compliance Review

Performance Results

Table 3-18 presents Amerigroup Iowa's scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in Amerigroup's written documents; including policies, procedures, reports, and meeting minutes; and interviews with MCO staff members. DHS required Amerigroup Iowa to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-18—Summary of Standard Compliance Scores for AGP

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
II	Member Rights and Member Information	20	20	16	4	0	**80%**
III	Emergency and Poststabilization Services	10	10	10	0	0	**100%**
IV	Availability of Services	9	9	9	0	0	**100%**
V	Assurances of Adequate Capacity and Services	5	5	5	0	0	**100%**
VI	Coordination and Continuity of Care	10	10	9	1	0	**90%**
VII	Coverage and Authorization of Services	10	10	8	2	0	**80%**
Total		**71**	**71**	**64**	**7**	**0**	**90%**

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: Amerigroup Iowa achieved full compliance in the Disenrollment: Requirements and Limitations program area, demonstrating that the MCO had adequate processes in place related to member and MCO requests for disenrollment, procedures for disenrollment, and use of the MCO's grievance system when receiving a disenrollment request. [**Quality**]

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

Strength #3: Amerigroup Iowa achieved full compliance in the Availability of Services program area, demonstrating that the MCO maintained and monitored a network of appropriate providers sufficient to provide adequate access to all services covered under its contract with DHS, including adherence to DHS' appointment standards (primary care, specialty care, hospital and emergency services, LTSS, behavioral health, optometry, and lab and x-ray) and cultural and accessibility consideration requirements. [**Timeliness** and **Access**]

Strength #3: Amerigroup Iowa achieved full compliance in the Assurances of Adequate Capacity and Services program area, demonstrating that the MCO maintained the capacity to serve its enrolled members according to DHS' time/distance standards (primary care, specialty care, hospital and emergency services, LTSS, behavioral health, optometry, lab and x-ray, and pharmacy). [**Timeliness** and **Access**]

Weaknesses and Recommendations

Weakness #1: Amerigroup Iowa received a score of 80 percent in the Member Rights and Member Information program area. Adequate implementation of these requirements is imperative to ensure that members receive timely and adequate access to information that can assist them in accessing care and services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Amerigroup Iowa received a *Not Met* score for four elements, and specifically:

- Amerigroup Iowa did not demonstrate an automatic process to distribute all critical member written materials in Spanish when a member's primary language was identified as such. [**Quality**]
- Amerigroup Iowa did not present evidence of implementation of a process to track timeliness of member notification of a terminated provider. [**Timeliness**]

- Amerigroup Iowa's provider directory lacked specificity of a provider's accessibility accommodations. [**Access**]
- Amerigroup Iowa did not maintain the capability to document a secure web portal as a member's preferred mode of communication or demonstrate a process to ensure that various departmental staff members would confirm a member's preferred mode of communication and send MCO-generated materials in that preferred mode (i.e., secure web portal). [**Quality** and **Access**]

It should be noted that three of these four elements also received a *Not Met* score during the CY 2020 compliance review activity. Amerigroup Iowa was continuing to work on its remediation plan to address those deficiencies, but the remediation plan had not yet been completed or implemented at the time of the CY 2021 review.

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

Weakness #2: Amerigroup Iowa received a score of 80 percent in the Coverage and Authorization of Services program area. Adequate implementation of service authorization requirements is needed to ensure that members receive timely and adequate notice of an adverse benefit determination (ABD) with their appeal rights. [**Quality** and **Timeliness**]

Why the weakness exists: Amerigroup Iowa received a *Not Met* score for two elements, and specifically:

- Amerigroup Iowa did not consistently inform members of the denied service within the written ABD notice. [**Quality**]
- Amerigroup Iowa did not provide evidence that it sent members an ABD notice for the denial of payment in a timely manner. Amerigroup Iowa was also approving services that failed to meet service authorization time frames, which contradicts the federal rule. [**Timeliness**]

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

Network Adequacy Validation

Performance Results

HSAG reviewed the demographics of members using telehealth services. About one in five Amerigroup Iowa members used telehealth services in CY 2020, as shown in Table 3-19. When adjusting for length of enrollment, the percentage of Amerigroup Iowa members who used telehealth services increased to almost one in four members. Table 3-20, Table 3-21, Table 3-22, and Table 3-23 show the rates of telehealth utilization for all members by age, sex, race, and geographic location, respectively.

Table 3-19—Percentage of Members Using Telehealth Services for AGP

MCO	Rate of MCO Members Using Telehealth	Weighted Rate of MCO Members Using Telehealth[1]
AGP	22.8%	24.1%
Statewide	22.5%	23.6%

[1] Rates are weighted by duration of enrollment in CY 2020.

Table 3-20—Use of Telehealth Services by Member Demographics for AGP—Age

Age	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
0–18	49.6%	37.7%	38.0%
19–21	5.0%	4.9%	4.9%
22–44	26.0%	33.6%	33.3%
45–64	14.8%	20.4%	20.5%
65+	4.6%	3.4%	3.3%

Note: MCO percentages may not total 100.0% due to rounding.
[1] Proportions are weighted by duration of enrollment in CY 2020.

Table 3-21—Use of Telehealth Services by Member Demographics for AGP—Sex

Sex	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
Female	54.8%	59.0%	59.2%
Male	45.2%	41.0%	40.8%

Note: MCO percentages may not total 100.0% due to rounding.
[1] Proportions are weighted by duration of enrollment in CY 2020.

Table 3-22—Use of Telehealth Services by Member Demographics for AGP—Race

Race	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
American Indian or Alaska Native	0.4%	0.5%	0.4%
Asian	1.7%	0.7%	0.7%
Black or African American	7.4%	6.0%	6.0%
Native Hawaiian and Other Pacific Islander	0.6%	0.5%	0.5%
Some Other Race	6.5%	4.0%	4.0%

Race	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
Two or More Races	3.7%	3.7%	3.7%
Unknown Race	29.2%	23.9%	23.8%
White	50.6%	60.8%	60.9%

Note: MCO percentages may not total 100.0% due to rounding.
[1] Proportions are weighted by duration of enrollment in CY 2020.

Table 3-23—Use of Telehealth Services by Member Geography for AGP

Geography	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
Rural	24.6%	22.2%	22.2%
Urban	75.4%	77.8%	77.8%

Note: MCO percentages may not total 100.0% due to rounding.
[1] Proportions are weighted by duration of enrollment in CY 2020.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV 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: About one in five Amerigroup Iowa members used telehealth services in CY 2020. Members of all ages, sexes, races, and geographic areas were identified as using telehealth services, indicating that telehealth services were available for a variety of members. [**Access**]

Weaknesses and Recommendations

Weakness #1: About 60 percent of all members who used telehealth services in CY 2020 were White, while accounting for approximately 50 percent of members overall. This represents a disproportionate number of White members using telehealth services compared to other races. [**Quality** and **Access**]

Why the weakness exists: This weakness may indicate a disproportionate lack of access to telehealth for non-White members. However, since an analysis of overall service utilization by race,

not limited to telehealth services, was outside the scope of this analysis, it is unknown how the racial composition of members using telehealth services may differ from that of overall service utilization.

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

Encounter Data Validation

Performance Results—CY 2020: Medical Record Review

Table 3-24 and Table 3-25 present the percentage of medical record documentation submissions and the major reasons medical record documentation was not submitted by Amerigroup Iowa, respectively.

Table 3-24—Summary of Medical Records Requested and Received for AGP

MCO	Number of Records Requested	Number of Records Submitted	Percent of Records Submitted
AGP	411	321	78.1%

Table 3-25—Reasons Medical Records Not Submitted for Date of Service for AGP

Reason	Number	Percent
Non-responsive provider or provider did not respond in a timely manner.	86	95.6%
Member was a patient of the practice; however, no documentation was available for requested dates of service.	2	2.2%
Other.	2	2.2%
Total	**90**	**100.0%**

Table 3-26 displays the medical record omission, encounter data omission, element accuracy, and all-element accuracy rates for each key data element.

Table 3-26—Encounter Data Completeness and Accuracy Summary for AGP

Key Data Element	Medical Record Omission[1]	Encounter Data Omission[2]	Element Accuracy[3]	Error Type
Date of Service	18.0%	3.2%	—	—
Diagnosis Code	26.0%	2.6%	99.4%	Inaccurate Code (85.7%) Specificity Error (14.3%)

Key Data Element	Medical Record Omission[1]	Encounter Data Omission[2]	Element Accuracy[3]	Error Type
Procedure Code	28.7%	4.5%	97.9%	Inaccurate Code (90.5%) Lower Level of Services in Medical Records (9.5%) Higher Level of Services in Medical Records (0.0%)
Procedure Code Modifier	36.3%	0.0%	99.5%	—
All-Element Accuracy[4]			68.5%	—

— Indicates that the accuracy rate analysis and/or the error type was not applicable to a given data element.

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

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

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

[4] The all-element accuracy rate describes the percentage of dates of service present in both DHS' encounter data and in the medical records with **all** data elements coded correctly (i.e., not omitted from the medical record; not omitted from the encounter data; and, when populated, have the same values). As such, the gray cells indicate the evaluation for medical record omission or encounter data omission is not applicable.

Strengths, Weaknesses, and Recommendations—CY 2020: Medical Record Review

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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: The encounter data omission rates were low for the evaluated data elements (i.e., date of service, diagnosis code, procedure code, and procedure code modifier), indicating that data elements found in the members' medical records were well supported by the data found in the electronic encounter data extracted from DHS' data warehouse. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Amerigroup Iowa had no medical record documentation submitted for 21.9 percent of the requested cases. [**Quality**]

Why the weakness exists: According to Amerigroup Iowa, the main reason for missing medical records was "*Non-responsive provider or provider did not respond in a timely manner.*"

Recommendation: HSAG recommends that Amerigroup Iowa consider strengthening and/or enforcing its contract requirements with its providers to ensure that documentation and/or records are easily accessible and providers respond in a timely manner when documentation and/or records are requested.

Weakness #2: The medical record omission rates were high for the evaluated data elements (i.e., date of service, diagnosis code, procedure code, and procedure code modifier). [**Quality**]

Why the weakness exists: While the high medical record omission rates for diagnosis code, procedure code, and procedure code modifier were largely related to the high rate of medical record nonsubmission, other reasons may have also contributed to the high rate. Some of the potential reasons include: (1) the provider did not document the services performed in the medical record, and (2) the provider did not provide the service(s) found in the encounter data.

Recommendation: HSAG recommends that Amerigroup Iowa consider performing periodic MRR of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews would then be shared with providers through periodic provider education and training regarding encounter data submission, medical record documentation, and coding practices.

Performance Results—CY 2021: Comparative Analysis

There are two aspects of record completeness—record omission and record surplus. Table 3-27 displays the percentage of records present in the files submitted by Amerigroup Iowa that were not found in the DHS-submitted files (record omission), and the percentage of records present in the DHS-submitted files but not present in Amerigroup Iowa-submitted files (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 3-27—Record Omission and Surplus Rates for AGP

Encounter Type	Omission	Surplus
Professional	0.4%	0.3%
Institutional	1.9%	1.9%
Pharmacy	5.3%	0.4%

Table 3-28 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the professional encounters for Amerigroup Iowa. For the element omission and surplus indicators, lower rates indicate better performance; while for element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 3-28—Data Element Omission, Surplus, Absent, and Accuracy: Professional Encounters for AGP

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Member Identification (ID)	0.0%	0.0%	0.0%	100.0%
Detail Service From Date	0.0%	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	0.0%	99.8%

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Billing Provider National Provider Identifier (NPI)	0.0%	4.1%	<0.1%	100.0%
Rendering Provider NPI	0.0%	48.5%	<0.1%	99.6%
Referring Provider NPI[A]	<0.1%	<0.1%	63.9%	100.0%
Primary Diagnosis Code	0.0%	0.0%	0.0%	100.0%
Secondary Diagnosis Code[A]	<0.1%	0.0%	54.1%	>99.9%
Procedure Code	0.0%	0.0%	0.0%	>99.9%
Procedure Code Modifier[A]	<0.1%	<0.1%	53.1%	>99.9%
Units of Service	0.0%	0.0%	0.0%	97.1%
National Drug Code (NDC)[A]	<0.1%	<0.1%	98.6%	99.7%
Detail Paid Amount	0.0%	0.0%	0.0%	99.3%

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

Table 3-29 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the institutional encounters for Amerigroup Iowa. For the element omission and surplus indicators, lower rates indicate better performance; while for element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 3-29—Data Element Omission, Surplus, Absent, and Accuracy: Institutional Encounters for AGP

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Member ID	0.0%	0.0%	0.0%	100.0%
Header Service From Date	0.0%	0.0%	0.0%	97.9%
Header Service To Date	0.0%	0.0%	0.0%	96.6%
Admission Date[A]	<0.1%	2.2%	81.1%	97.1%
Billing Provider NPI	0.0%	0.0%	0.0%	100.0%
Attending Provider NPI	1.0%	0.0%	<0.1%	100.0%
Referring Provider NPI[A]	0.0%	0.0%	99.3%	100.0%
Primary Diagnosis Code	0.0%	<0.1%	0.0%	100.0%
Secondary Diagnosis Code[A]	<0.1%	0.0%	18.4%	>99.9%
Procedure Code[A]	0.0%	0.0%	16.8%	100.0%
Procedure Code Modifier[A]	0.0%	0.0%	76.4%	100.0%
Units of Service	0.0%	0.0%	0.0%	90.5%
Primary Surgical Procedure Code[A]	0.5%	0.6%	95.1%	>99.9%
Secondary Surgical Procedure Code[A]	0.4%	0.4%	96.9%	100.0%
NDC[A]	0.2%	0.2%	91.5%	96.3%
Revenue Code	0.0%	0.0%	0.0%	100.0%
Diagnosis-Related Group (DRG) Code[A]	<0.1%	2.1%	91.6%	>99.9%

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Header Paid Amount	0.0%	0.0%	0.0%	95.7%
Detail Paid Amount	0.0%	0.0%	0.0%	98.8%

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

Table 3-30 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the pharmacy encounters for Amerigroup Iowa. For the element omission and surplus indicators, lower rates indicate better performance, while for the element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or worse performance.

Table 3-30—Data Element Omission, Surplus, Absent, and Accuracy: Pharmacy Encounters for AGP

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Member ID	0.0%	<0.1%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	100.0%
Billing Provider NPI	0.0%	<0.1%	0.0%	>99.9%
Prescribing Provider NPI	0.0%	<0.1%	0.0%	>99.9%
NDC	<0.1%	<0.1%	0.0%	99.9%
Drug Quantity	0.0%	<0.1%	0.0%	96.5%
Header Paid Amount	0.0%	<0.1%	0.0%	>99.9%
Dispensing Fee	0.0%	<0.1%	0.0%	98.9%

Table 3-31 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing or non-missing) for all key data elements relevant to each encounter data type for Amerigroup Iowa. Of note, an adjustment was made in calculating the all-element accuracy indicator for professional encounters. For professional encounters, while the *Rendering Provider NPI* data element was included in the individual data element assessment (i.e., element omission, element surplus, and element accuracy), this data element was not included in the calculation of the all-element accuracy rate. This is due to the knowledge that the way this data element was processed and populated in DHS' Medicaid Management Information System (MMIS) deviated from how the values were submitted by the MCOs to DHS. For the all-element accuracy indicator, higher rates indicate better performance.

Table 3-31—All-Element Accuracy and Encounter Type for AGP

Professional Encounters	Institutional Encounters	Pharmacy Encounters
94.9%	85.4%	95.3%

Strengths, Weaknesses, and Recommendations—CY 2021: Comparative Analysis

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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: Amerigroup Iowa's professional and institutional encounters exhibited complete data with low record omission and record surplus rates. [**Quality**]

Strength #2: For pharmacy encounters, the record surplus rate was very low at 0.4 percent, suggesting that nearly all of the encounters in DHS' data warehouse were corroborated by data extracted from Amerigroup Iowa's data system. The record omission rate was moderately high at 5.3 percent; however, it was determined that the majority of the omitted records appeared to be associated with records that were either adjusted or voided. [**Quality**]

Strength #3: Among encounters that could be matched between data extracted from DHS' data warehouse and data extracted from Amerigroup Iowa's data system, a high level of element completeness (i.e., low element omission and surplus rates) was exhibited. [**Quality**]

Strength #4: Among encounters that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values) was exhibited, with very few exceptions. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The accuracy rate for the NDC data element within the institutional encounters was moderately low at 96.3 percent. [**Quality**]

Why the weakness exists: The mismatches for this data element were due to misalignment of the populated NDCs. Amerigroup Iowa noted that it pulled the NDC data element from a different source than was reported by the DHS-submitted data.

Recommendation: HSAG recommends that Amerigroup Iowa research the issue further and provide an explanation as to the differences in values from the different sources of data.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-32 presents Amerigroup Iowa's 2021 adult Medicaid, general child Medicaid, and children with chronic conditions (CCC) Medicaid CAHPS top-box scores. Arrows (↓ or ↑) indicate 2021 scores that were at least 5 percentage points higher or lower than the 2020 national average.

Table 3-32—Summary of 2021 CAHPS Top-Box Scores for AGP

	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid Supplemental
Composite Measures			
Getting Needed Care	88.1% ↑	90.9%	90.4%
Getting Care Quickly	84.7%	90.0%	92.5%
How Well Doctors Communicate	95.8%	96.0%	97.1%
Customer Service	NA	89.9%	86.8%
Global Ratings			
Rating of All Health Care	62.3%	74.6%	70.1%
Rating of Personal Doctor	73.3%	81.6%	81.3%
Rating of Specialist Seen Most Often	68.5%	76.8%	74.0%
Rating of Health Plan	65.4%	68.5%	62.7% ↓
Effectiveness of Care*			
Advising Smokers and Tobacco Users to Quit	70.8% ↓		
Discussing Cessation Medications	43.1% ↓		
Discussing Cessation Strategies	39.5% ↓		
CCC Composite Measures/Items			
Access to Specialized Services			74.6%
Family Centered Care (FCC): Personal Doctor Who Knows Child			93.5%
Coordination of Care for Children With Chronic Conditions			78.1%
Access to Prescription Medicines			92.2%
FCC: Getting Needed Information			91.7%

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 2021 score is at least 5 percentage points greater than the 2020 national average.
↓ Indicates the 2021 score is at least 5 percentage points less than the 2020 national average.
Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the results for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the results of the CAHPS 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: Adult members had positive experiences with getting the care they needed since the score for the *Getting Needed Care* measure was at least 5 percentage points greater than the 2020 NCQA adult Medicaid national average. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: For the CCC Medicaid population, parents/caretakers of child members had less positive overall experiences with their child's health plan. The score for the *Rating of Health Plan* measure was at least 5 percentage points less than the 2020 NCQA Medicaid national average. [**Quality**, **Timeliness**, and **Access**]

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

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

Weakness #2: For the Adult Medicaid population, adult members had less positive overall experiences with all three Effectiveness of Care measures. The scores for the *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* measures were at least 5 percentage points less than the 2020 NCQA Medicaid national averages. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicated that Amerigroup Iowa providers may not be discussing cessation medications and strategies and advising members who smoke or use tobacco to quit as much as other providers.

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

Quality Rating

The 2021 Iowa Health Link 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 Quality Rating activity in Section 7—MCP Comparative Information to review the 2021 Iowa Health Link MCO Scorecard, which is inclusive of Amerigroup Iowa's performance.

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

To identify strengths and weaknesses and draw conclusions for Amerigroup Iowa about the quality, timeliness, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by Amerigroup Iowa across all EQR activities to identify common themes within Amerigroup Iowa that impacted, or will have the likelihood to impact, member health outcomes. The overarching aggregated findings show that Amerigroup Iowa had an adequate network of providers to provide services to its members, and effective processes, procedures, and monitoring efforts in place to continually evaluate its provider network for necessary network enhancements as determined through high performance in the Availability of Services and Assurances of Adequate Capacity and Services compliance review standards. HEDIS performance within the Keeping Kids Healthy domain also supported that children were able to access their primary care providers in a timely manner to obtain recommended vaccinations and preventive screenings, as demonstrated through the *Childhood Immunization Status* and *Lead Screening in Children* HEDIS measure indicators performing at or above the national Medicaid 75th percentile.

However, even though Amerigroup Iowa appeared to have an adequate network for all of its members, and adult members specifically reported good experiences with getting needed care as indicated through the higher-performing *Getting Needed Care* CAHPS measure, the adult population was not always accessing services in a timely manner to obtain the preventive and/or condition-specific care they needed to maintain optimal health, as indicated through lower-performing HEDIS rates in the Access to Preventive Care, Women's Health, and Living With Illness HEDIS measure domains. Specifically, six of seven rates within the Access to Preventive Care domain, five of six rates within the Women's Health domain, and three of six nationally comparable rates within the Living With Illness domain performed below the national Medicaid 50th percentile, indicating opportunities to improve the prevalence of timely access to services (specifically for adult members) in those measure domains. Eight of 18 rates within the Medication Management domain also performed below the national Medicaid 50th percentile, suggesting that both child and adult members may have experienced barriers to accessing care or their providers were not effectively treating members' conditions through appropriate medication management.

Amerigroup Iowa should assess whether inappropriate medication management is related to member visit noncompliance or whether the prescribing patterns (or lack thereof) were related to provider quality of care issues. Improvement in medication management should demonstrate overall improvement in member health outcomes, especially for those members with chronic conditions. Additionally, although Amerigroup Iowa continued its *Timeliness of Postpartum Care* PIP in CY 2021, the *Prenatal and Postpartum Care—Postpartum Care* HEDIS measure indicator rate was below the national Medicaid

25th percentile, indicating that Amerigroup Iowa's interventions (member and provider education efforts) may not be effectively reducing the barriers members were facing to timely access to postpartum care and/or were not positively impacting Amerigroup Iowa's processes to effectively calculate HEDIS performance measure data for the *Prenatal and Postpartum Care* measure rates. As such, Amerigroup Iowa should frequently evaluate its quality improvement interventions to assess whether the interventions are providing the intended results, and modify these interventions when appropriate, to support performance improvement.

Although potential concerns were identified with members' access to preventive and specialty care, access to behavioral health treatment was an exception. Specifically, Amerigroup Iowa demonstrated high performance related to following up with members who were hospitalized for or had an ED visit for behavioral health-related conditions, including mental illness and alcohol and other drug abuse or dependence, as supported by eight measure indicator rates related to follow-up care and initiation of treatment performing at or above the national Medicaid 75th percentile, and five of those measure indicator rates performing at or above the national Medicaid 90th percentile. The *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* HEDIS measure rates also demonstrated an improvement from the prior year and/or performed above the national Medicaid 75th percentile. Amerigroup Iowa also performed strongly in the Coordination and Continuity of Care compliance review standard, suggesting that performance in these behavioral health performance measure rates may have been positively impacted by effective care coordination processes to ensure members were getting the necessary care they needed, especially after treatment for behavioral health conditions, and that Amerigroup Iowa was committed to improving physical and mental function and reducing repeat ED visits, hospital readmissions, and healthcare spending.

As Amerigroup Iowa assesses its performance over the past CY, it should consider how telehealth services can be leveraged to support improved member outcomes. According to the NAV study, one in five Amerigroup Iowa members used telehealth services in CY 2020, indicating telehealth was available and was being used by a large number of members. Amerigroup Iowa should specifically consider whether it can promote the use of telehealth for services that were not being accessed by members when necessary, including visits for medication management, such as for children prescribed ADHD medications or adults taking an antidepressant medication. Additionally, Amerigroup Iowa should evaluate its CAHPS performance to identify whether negative experiences reported by members could potentially correlate to any issues identified in members' access to timely and quality services.

Of note, due to the COVID-19 pandemic during HEDIS MY 2020 and CY 2021, many preventive services were negatively affected across the country as states followed orders to reduce the use of nonemergent services in order to slow the spread of coronavirus disease. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have impacted performance outcomes in CY 2021.

Iowa Total Care

Performance Improvement Projects

Performance Results

Table 3-33 displays the overall validation status and baseline results for each PIP topic.

Table 3-33—Overall Validation Rating for ITC

PIP Topic	Validation Rating	Study Indicator	Study Indicator Results		
			Baseline	R1	R2
Timeliness of Postpartum Care	*Met*	The percentage of women who delivered a live birth on or between October 8th of the year prior to the measurement year and October 7th of the measurement year who had a postpartum care visit on or between 7 and 84 days after delivery.	72.5%		
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%		

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

The PIP process includes three phases—I. Design, II. Implementation, and III. Outcomes. During 2021, the Iowa Total Care's interventions were not assessed for the *Timeliness of Postpartum Care* topic, as the MCO completed the Design stage but had not yet completed the Implementation and Outcomes stages, and therefore had not progressed to the point of developing and implementing improvement strategies and interventions. Table 3-34 displays the interventions implemented to address the barriers identified by Iowa Total Care through the use of QI and causal/barrier analysis processes for the *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed* topic.

Table 3-34—Interventions for ITC

Intervention Descriptions	
Timeliness of Postpartum Care	***CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed***
The MCO has not progressed to implementing interventions for this PIP topic. Interventions for this PIP topic will be reported in the next annual EQR report.	Updated internal employee communication methods to ensure timely dissemination of program materials.
	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.
	Utilized after-call surveys and quality checks to ensure agents are performing as expected.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Iowa Total Care designed a methodologically sound PIP for the *Timeliness of Postpartum Care* PIP topic to support improvement for women receiving postpartum care. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Iowa Total Care had opportunities to improve its documentation related to data collection methods for the *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed* PIP topic. The gaps identified in the data collection process may impact the MCO's ability to ensure data accuracy and validity. [**Quality**]

Why the weakness exists: Iowa Total Care did not provide all required components in its data collection methods, such as its sampling frame size, margin of error, and confidence level.

Recommendation: HSAG recommends that Iowa Total Care completely document its methods for collecting its data and how it generated its sample size for the eligible population.

Weakness #2: Iowa Total Care did not conduct an appropriate causal/barrier analysis process or document its method for prioritizing the barriers identified for the *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed* PIP topic, indicating that the MCO may not have a complete understanding of all factors impacting member satisfaction. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Iowa Total Care documented improvement strategies that were unclear or incomplete.

Recommendation: HSAG recommends that Iowa Total Care use appropriate QI tools to identify existing opportunities for improvement within its current processes. The results will support the MCO's approach for developing specific and targeted interventions to address the barriers identified.

Performance Measure Validation

Performance Results

HSAG reviewed Iowa Total Care's eligibility and enrollment data, claims and encounters and case management systems, plan of care process, and data integration process, which included live

demonstrations of each system. Overall, Iowa Total Care demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with Iowa Total Care's processes. Additionally, Iowa Total Care was able to answer HSAG's questions, and HSAG did not identify any issues during the PSV interview session, which included a focus on member-specific enrollment, claims, and case management data to support performance measures #1, 2, 3, 4, 5, and 6.

Table 3-35, Table 3-36, Table 3-37, and Table 3-38 display measure designation and reportable measure rates for SFY 2021. While individual rates are produced for each of the eight waiver populations, only the aggregate rate is displayed. Iowa Total Care received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 3-35—#1a Performance Measure Designation and Rates for ITC*

Performance Measure		Measure Designation	Measure Rate				
			0%	1–49%	50–74%	75–89%	90–100%
1a	*Percentage of Eligible Members With Applicable Percentage of Authorized Services Utilized*	*R*	8.69%	59.61%	17.65%	4.92%	9.13%

* 2021 rates are provided for information only.

Table 3-36—#1b Performance Measure Designation and Rates for ITC*

Performance Measure		Measure Designation	Measure Rate
1b	*The Percentage of Eligible Members For Whom 100 Percent of HCBS Documented in Members' Care Plans Had a Corresponding Approved Service Authorization*	*R*	89.03%

* 2021 rates are provided for information only.

Table 3-37—#2 Performance Measure Designation and Rates for ITC*

Performance Measure		Measure Designation	Measure Results		
			Denominator	Numerator	Rate
2a	*Members With One or More Documented Care Plan One-Time Service*	*R*	1,139	4	0.35%
2b	*Members With Documented Care Plan One-Time Service With Corresponding Approved Service Authorization*	*R*	4	4	100.00%
2c	*Percentage of Authorized One-Time Services Utilized*	*R*	4	3	75.00%

* 2021 rates are provided for information only.

Table 3-38—#3, #4, #5, and #6 Performance Measure Designation and Rates for ITC

Performance Measure		Measure Designation	Measure Results		
			Denominator	Numerator	Rate
3	*Provision of Care Plan*	*R*	1,101	924	83.92%
4	*Person-Centered Care Plan Meeting**	*R*	1,101	1,043	94.73%
5	*Care Team Lead Chosen by the Member*	*R*	1,101	1,062	96.46%
6	*Member Choice of HCBS Settings*	*R*	1,101	1,055	95.82%

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV 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: Iowa Total Care deployed an agile approach to ensuring the health and safety of its LTSS members throughout the COVID-19 public health emergency. It used the resources at its disposal to authorize services that were more widely available for members while still finding ways to maintain flexibility so that preferred services could be accessed easily when they became available again. Iowa Total Care performed outreach to check on member needs and watched for adjustments that were needed due to limited service availability in certain areas. [**Access**]

Strength #2: Iowa Total Care prioritized the configuration of reportable fields within its member reporting assessment (MRA) in TruCare, Iowa Total Care's care management system, and initiated a feedback loop with front line LTSS staff members for testing the system as well as documentation enhancements. As a result, the MCO has been able to reach its goal of 100 percent administrative reporting for Iowa Total Care's internal data for all performance measures and can impact performance rates as it monitors them throughout the year, which supports the accuracy of reporting performance measures. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Iowa Total Care relied entirely on manual abstraction of care coordination and service plan records for measures #3 through #6 for members enrolled in IHHs, which introduces the

risk of human error and requires duplication of effort by clinical staff members for care coordination documentation, potentially impacting reporting. [**Quality**]

Why the weakness exists: IHH clinical staff members who worked directly with members did not have access to the Iowa Total Care TruCare system. They documented all activities in their own electronic medical record and sent copies of documentation to Iowa Total Care staff members for abstraction.

Recommendation: Iowa Total Care should consider providing limited system access in TruCare (e.g., user credentials are limited to only viewing and editing records for IHH members) to IHH clinical staff members for documenting care coordination and service plan data for performance measure reporting. This would potentially provide Iowa Total Care with efficiencies by preserving Iowa Total Care clinical staff time for clinical activities. It would also reduce the potential for errors in reporting.

Performance Results—HEDIS

HSAG's review of the FAR for HEDIS MY 2020 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 2020. Iowa Total Care contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

Table 3-39—HEDIS MY 2020 Results for ITC

Measures	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	Three-Year Trend	HEDIS MY 2020 Star Rating
Access to Preventive Care					
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	—	—	77.47%	—	★★
45–64 Years	—	—	85.78%	—	★★
65 Years and Older	—	—	81.78%	—	★
Use of Imaging Studies for Low Back Pain					
Use of Imaging Studies for Low Back Pain	—	—	69.46%	—	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile Documentation—Total	—	—	69.83%	—	★
Counseling for Nutrition—Total	—	—	61.56%	—	★
Counseling for Physical Activity—Total	—	—	55.72%	—	★
Women's Health					
Breast Cancer Screening					
Breast Cancer Screening	—	—	NA	—	NC
Cervical Cancer Screening					
Cervical Cancer Screening	—	—	49.64%	—	★

Measures	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	Three-Year Trend	HEDIS MY 2020 Star Rating
Chlamydia Screening in Women					
Total	—	—	45.61%	—	★
Non-Recommended Cervical Cancer Screening in Adolescent Females					
Non-Recommended Cervical Cancer Screening in Adolescent Females	—	—	0.61%	—	★★★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	—	—	69.59%	—	★
Postpartum Care	—	—	72.51%	—	★★
Living With Illness					
Comprehensive Diabetes Care					
HbA1c Testing	—	—	85.64%	—	★
HbA1c Control (<8.0%)	—	—	38.93%	—	★
*HbA1c Poor Control (>9.0%)**	—	—	50.12%	—	★
Blood Pressure Control (<140/90 mm Hg)	—	—	65.21%	—	NC
Eye Exam (Retinal) Performed	—	—	51.82%	—	★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	—	62.53%	—	NC
Statin Therapy for Patients With Cardiovascular Disease					
Received Statin Therapy—Total	—	—	NA	—	NC
Statin Therapy for Patients With Diabetes					
Received Statin Therapy	—	—	NA	—	NC
Behavioral Health					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	—	—	43.47%	—	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	—	73.54%	—	★
Follow-Up After ED Visit for AOD Abuse or Dependence					
7 Day Follow-Up—Total	—	—	44.17%	—	★★★★★
30 Day Follow-Up—Total	—	—	50.95%	—	★★★★★
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—Total	—	—	61.36%	—	★★★★
30-Day Follow-Up—Total	—	—	72.48%	—	★★★★
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	—	—	30.72%	—	★★

Measures	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	Three-Year Trend	HEDIS MY 2020 Star Rating
30-Day Follow-Up—Total	—	—	50.94%	—	★★
Initiation and Engagement of AOD Abuse or Dependence Treatment					
Initiation of AOD Treatment—Total	—	—	76.18%	—	★★★★★
Engagement of AOD Treatment—Total	—	—	28.41%	—	★★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose and Cholesterol Testing–Total	—	—	20.76%	—	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	—	—	59.16%	—	★★
Keeping Kids Healthy					
Childhood Immunization Status					
Combination 3	—	—	70.07%	—	★★
Combination 10	—	—	41.36%	—	★★★
Immunizations for Adolescents					
Combination 1	—	—	84.18%	—	★★★
Combination 2	—	—	28.71%	—	★
Lead Screening in Children					
Lead Screening in Children	—	—	77.62%	—	★★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	34.58%	—	NC
Well-Child Visits for Age 15 Months-30 Months—Two or More Well-Child Visits	—	—	60.51%	—	NC
Child and Adolescent Well-Care Visits					
Total	—	—	38.02%	—	NC
Medication Management					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	—	—	60.76%	—	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	55.31%	—	★★★
Effective Continuation Phase Treatment	—	—	40.78%	—	★★★
Appropriate Testing for Pharyngitis					
Total	—	—	80.22%	—	★★★
Appropriate Treatment for Upper Respiratory Infection					
Total	—	—	86.54%	—	★★
Asthma Medication Ratio					
Total	—	—	NA	—	NC

Measures	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	Three-Year Trend	HEDIS MY 2020 Star Rating
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Total	—	—	51.14%	—	★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	—	—	54.49%	—	★★★★
Continuation and Maintenance Phase	—	—	61.19%	—	★★★
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	—	—	67.78%	—	★
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	—	—	42.43%	—	★
Bronchodilator	—	—	49.03%	—	★
Statin Therapy for Patients With Cardiovascular Disease					
Statin Adherence 80%—Total	—	—	NA	—	NC
Statin Therapy for Patients With Diabetes					
Statin Adherence 80%	—	—	NA	—	NC
Use of Opioids at High Dosage*					
Use of Opioids at High Dosage	—	—	2.25%	—	★★★★
Use of Opioids From Multiple Providers*					
Multiple Prescribers	—	—	15.87%	—	★★★★
Multiple Pharmacies	—	—	1.64%	—	★★★★★
Multiple Prescribers and Multiple Pharmacies	—	—	1.22%	—	★★★★

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

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

NC Indicates that a comparison is not appropriate, or the prior year's rate was unavailable.

HEDIS MY 2020 star ratings represent the following percentile comparisons:

★★★★★ = At or above the 90th percentile

★★★★ = At or above the 75th percentile but below the 90th percentile

★★★ = At or above the 50th percentile but below the 75th percentile

★★ = At or above the 25th percentile but below the 50th percentile

★ = Below the 25th percentile

Strengths, Weaknesses, and Recommendations—SFY 2021

Through the EQR, HSAG assessed the findings for the HEDIS activity against the domains of quality, timeliness, and access to care. Substantial strengths and weaknesses within the findings of the HEDIS 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: Iowa Total Care's performance under the Behavioral Health domain ranked at or above the 90th percentile for four of the 12 indicators: *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up* and *30-Day Follow-Up* and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* and *Engagement of AOD Treatment*. Additionally, Iowa Total Care's performance ranked between the 75th and 89th percentiles for *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*. The rates for these indicators show that Iowa Total Care was engaged in providing follow-up treatment services to improve physical and mental function and reduce repeat ED visits, hospital readmissions, and healthcare spending. Additionally, due to the addition of telehealth services to the MY 2020 measure specifications, achieving rates for these indicators at or above the 75th percentile likely indicates a high adoption rate for telehealth services during the COVID-19 pandemic. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Iowa Total Care's performance under the Medication Management domain ranked at or above the 90th percentile for the *Use of Opioids From Multiple Providers—Multiple Pharmacies* indicator and ranked between the 75th and 89th percentiles for the *Use of Opioids at High Dosage* indicator and *Use of Opioids From Multiple Providers—Multiple Prescribers* indicator. The rates for these indicators show that Iowa Total Care was engaged in working with providers to limit access to habit-forming medications when not medically necessary. [**Quality**]

Strength #3: As related to quality of care, Iowa Total Care's performance under the Medication Management domain ranked between the 75th and 89th percentiles for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*. The rate for this indicator shows that Iowa Total Care was engaged in working with providers to ensure members were receiving appropriate monitoring of medication effectiveness and side effects while initiating a new medication. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Iowa Total Care's performance under the Women's Health domain ranked below the 25th percentile for the *Cervical Cancer Screening*, *Chlamydia Screening in Women*, and *Prenatal and Postpartum Care—Timeliness of Prenatal* indicators, indicating that a large number of women were not being seen or screened by their providers. Cervical cancer is one of the most common causes of cancer death for American women, while untreated chlamydia infections can lead to serious and irreversible complications. Additionally, timely and adequate prenatal care can promote the long-term health and wellbeing of new mothers and their infants. [**Quality**, **Timeliness** and **Access**]

Why the weakness exists: The low rates for *Cervical Cancer Screening* and *Chlamydia Screening in Women* suggest that barriers exist for sexually active women between 16 and 24 years of age and women between 21 and 64 years of age to access these important health screenings, and the COVID-19 pandemic may have increased these barriers. Additionally, the low *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator rate suggests that women were experiencing barriers to timely access to providers for prenatal care.

Recommendation: HSAG recommends that Iowa Total Care partner with primary care and OB-GYN providers to conduct a focused study to determine why some female members 16 to 24 years of age identified as sexually active were not getting screened for chlamydia and why some female members 21 to 64 years of age were not getting screened for cervical cancer. In addition, HSAG recommends that Iowa Total Care conduct a focused study to determine why some female members were not receiving timely prenatal care. Upon identification of a root cause, Iowa Total Care should implement appropriate interventions (e.g., member incentives, promotion of telehealth services for prenatal care) to improve low performance rates within the Women's Health domain.

Weakness #2: Iowa Total Care's performance under the Behavioral Health domain ranked below the 25th percentile for *Diabetes Monitoring for People With Diabetes and Schizophrenia*, *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, and *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing*. These low rates indicate that patients receiving behavioral health treatment using antipsychotic medication were not always being monitored or screened properly. Addressing the physical health needs of members diagnosed with mental health conditions is an important way to improve overall health, quality of life, and economic outcomes. Additionally, monitoring of blood glucose and cholesterol testing are important components of ensuring appropriate management of children and adolescents on antipsychotic medications. [**Quality**]

Why the weakness exists: While the root cause of these weaknesses is currently unclear, these low rates suggest that there are barriers to appropriate access to key health screenings and monitoring for adults and children with severe and persistent mental illness who are being treated with psychotropic medication.

Recommendation: HSAG recommends that Iowa Total Care partner with providers such as community mental health centers that treat the SPMI population to conduct a root cause analysis or focused study to determine why some members with severe mental illnesses are not being screened for diabetes or monitored for metabolic functioning. Upon identification of a root cause, Iowa Total Care should work with providers to implement appropriate interventions (e.g., process improvements, patient education campaign, provider incentives) to improve the performance rates of these measures.

Weakness #3: Iowa Total Care's performance under the Living With Illness domain ranked below the 25th percentile for four of the eight indicators: *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Control (<8.0%)*, *HbA1c Poor Control (>9.0%*), and *Eye Exam (Retinal) Performed*. These rates indicate that some members 18 to 75 years of age were not receiving proper diabetes management to help control their blood glucose and reduce the risk of complications related to type 1 and type 2 Diabetes. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. [**Quality and Access**]

Why the weakness exists: While the root cause of these weaknesses is currently unclear, these low rates suggest that there are barriers to appropriate access to key monitoring services for adults living with type 1 and type 2 diabetes.

Recommendation: HSAG recommends that Iowa Total Care partner with endocrine and primary care providers to conduct a root cause analysis or focused study to determine why some members with diabetes are not being tested regularly for their HbA1c level or having eye exams performed when recommended. Upon identification of a root cause, Iowa Total Care should work with providers to implement appropriate interventions (e.g., process improvements, patient education campaign, member or provider incentives) to improve the performance rates of these measures.

Compliance Review

Performance Results

Table 3-40 presents Iowa Total Care's scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in Iowa Total Care's written documents; including policies, procedures, reports, and meeting minutes; and interviews with MCO staff members. DHS required Iowa Total Care to submit a CAP for all standards scoring less than 100 percent compliant.

Table 3-40—Summary of Standard Compliance Scores for ITC

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Disenrollment: Requirements and Limitations	7	7	5	2	0	**71%**
II	Member Rights and Member Information	20	20	18	2	0	**90%**
III	Emergency and Poststabilization Services	10	10	10	0	0	**100%**
IV	Availability of Services	9	9	8	1	0	**89%**
V	Assurances of Adequate Capacity and Services	5	5	5	0	0	**100%**
VI	Coordination and Continuity of Care	10	10	10	0	0	**100%**
VII	Coverage and Authorization of Services	10	10	8	2	0	**80%**
Total		**71**	**71**	**64**	**7**	**0**	**90%**

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: Iowa Total Care achieved full compliance in the Emergency and Poststabilization Services program area, demonstrating that the MCO had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services. [**Access**]

Strength #2: Iowa Total Care achieved full compliance in the Assurances of Adequate Capacity and Services program area, demonstrating that the MCO maintained the capacity to serve its enrolled members according to DHS' time/distance standards (primary care, specialty care, hospital and emergency services, LTSS, behavioral health, optometry, lab and x-ray, and pharmacy). Iowa Total Care also added telehealth providers to serve members residing in rural areas. [**Timeliness** and **Access**]

Strength #3: Iowa Total Care achieved full compliance in the Coordination and Continuity of Care program area, demonstrating that the MCO had adequate processes to provide care coordination services for members, identify and assess members who have a special healthcare need in a timely manner, and develop care plans for members who have special healthcare needs. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Iowa Total Care received a score of 71 percent in the Disenrollment: Requirements and Limitations program area. Adequate implementation of these requirements is imperative to ensure that members understand their rights under which they can request disenrollment and the appropriate procedures to do so. [**Quality** and **Access**]

Why the weakness exists: Iowa Total Care received a *Not Met* score for two elements, and specifically:

- The member handbook did not inform members receiving LTSS of their right to request disenrollment if the member would have to change their residential, institutional, or employment supports provider based on that provider's change in status with the MCO and, as a result, would experience a disruption in their residence or employment. [**Quality** and **Access**]
- The member disenrollment letters reviewed did not include accurate information or did not inform the member to contact DHS to request disenrollment if the member remained dissatisfied with the results of the grievance process. [**Quality** and **Access**]

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

Weakness #2: Iowa Total Care received a score of 80 percent in the Coverage and Authorization of Services program area. Adequate implementation of service authorization requirements is needed to ensure that members receive timely and adequate ABD notice that includes their appeal rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Iowa Total Care received a *Not Met* score for two elements, and specifically:

- Iowa Total Care did not demonstrate adequate processes to ensure that members received an ABD notice for previously authorized services that were terminated, suspended, or reduced in accordance with federally required time frames; did not provide evidence to support a process for ensuring that members received an ABD notice, with appeal and State fair hearing rights, on the date the MCO makes a denial of payment; and did not provide sufficient evidence to support a process to identify out-of-compliance authorization requests or an ABD template with a rationale specific to noncompliant authorization time frames. [**Quality**, **Timeliness**, and **Access**]
- Iowa Total care did not demonstrate that it consistently provided members with a timely ABD notice. [**Timeliness**]

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

Network Adequacy Validation

Performance Results

HSAG reviewed the demographics of members using telehealth services. About one in five members used telehealth services in CY 2020 for Iowa Total Care, as shown in Table 3-41. Table 3-42, Table 3-43, Table 3-44, and Table 3-45 show the rates of telehealth utilization for all members by age, sex, race, and geographic location, respectively.

Table 3-41–Percentage of Members Using Telehealth Services for ITC

MCO	Rate of MCO Members Using Telehealth	Weighted Rate of MCO Members Using Telehealth[1]
ITC	21.2%	22.6%
Statewide	22.5%	23.6%

[1] Rates are weighted by duration of enrollment in CY 2020.

Table 3-42—Use of Telehealth Services by Member Demographics for ITC—Age

Age	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
0–18	46.6%	34.5%	34.9%

Age	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
19–21	5.0%	4.9%	4.9%
22–44	28.3%	37.2%	36.8%
45–64	15.3%	20.3%	20.4%
65+	4.9%	3.1%	3.1%

Note: MCO percentages may not total 100.0% due to rounding.

[1] Proportions are weighted by duration of enrollment in CY 2020.

Table 3-43—Use of Telehealth Services by Member Demographics for ITC—Sex

Sex	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
Female	54.5%	58.9%	59.1%
Male	45.5%	41.1%	40.9%

Note: MCO percentages may not total 100.0% due to rounding.

[1] Proportions are weighted by duration of enrollment in CY 2020.

Table 3-44—Use of Telehealth Services by Member Demographics for ITC—Race

Race	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
American Indian or Alaska Native	0.3%	0.4%	0.3%
Asian	1.9%	0.9%	0.9%
Black or African American	8.2%	6.5%	6.5%
Native Hawaiian and Other Pacific Islander	0.6%	0.5%	0.5%
Some Other Race	6.8%	4.3%	4.3%
Two or More Races	3.7%	3.8%	3.8%
Unknown Race	28.5%	23.4%	23.2%
White	49.9%	60.3%	60.4%

Note: MCO percentages may not total 100.0% due to rounding.

[1] Proportions are weighted by duration of enrollment in CY 2020.

Table 3-45—Use of Telehealth Services by Member Geography for ITC

Geography	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
Rural	23.5%	21.2%	21.2%
Urban	76.5%	78.8%	78.8%

Note: MCO percentages may not total 100.0% due to rounding.

[1] Proportions are weighted by duration of enrollment in CY 2020.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV 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: About one in five Iowa Total Care members used telehealth services in CY 2020. Members of all ages, sexes, races, and geographic areas were identified as using telehealth services, indicating that telehealth services were available for a variety of members. [**Access**]

Weaknesses and Recommendations

Weakness #1: About 60 percent of all members who used telehealth services in CY 2020 were White, while accounting for approximately 50 percent of members overall. This represents a disproportionate number of White members using telehealth services compared to other races. [**Quality** and **Access**]

Why the weakness exists: This weakness may indicate a disproportionate lack of access to telehealth for non-White members. However, since an analysis of overall service utilization by race, not limited to telehealth services, was outside the scope of this analysis, it is unknown how the racial composition of members using telehealth services may differ from that of overall service utilization.

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

Encounter Data Validation

Performance Results—CY 2020: Administrative Profile Analysis

Encounter Data Completeness

The encounter record counts measure evaluates the total number of line items received and processed by the MMIS in each MMIS month (i.e., the month when encounters were received by MMIS). Figure 3-2 and Figure 3-3 display Iowa Total Care's results for professional encounters (i.e., Health Care Financing Administration (HCFA-1500, Medicare Part B crossover, and waiver), institutional encounters (i.e., inpatient, inpatient crossover, long-term care, outpatient, and outpatient crossover), and pharmacy encounters, respectively.

Figure 3-1 —Professional Encounter Record Counts by Category of Service and MMIS Month for ITC

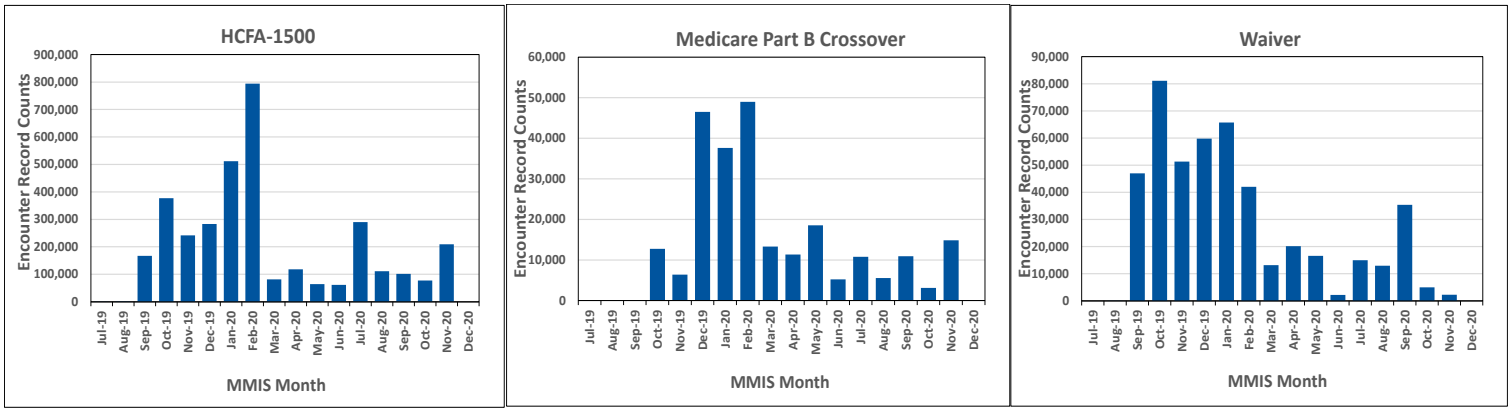


Figure 3-2—Institutional Encounter Record Counts by Category of Service and MMIS Month for ITC

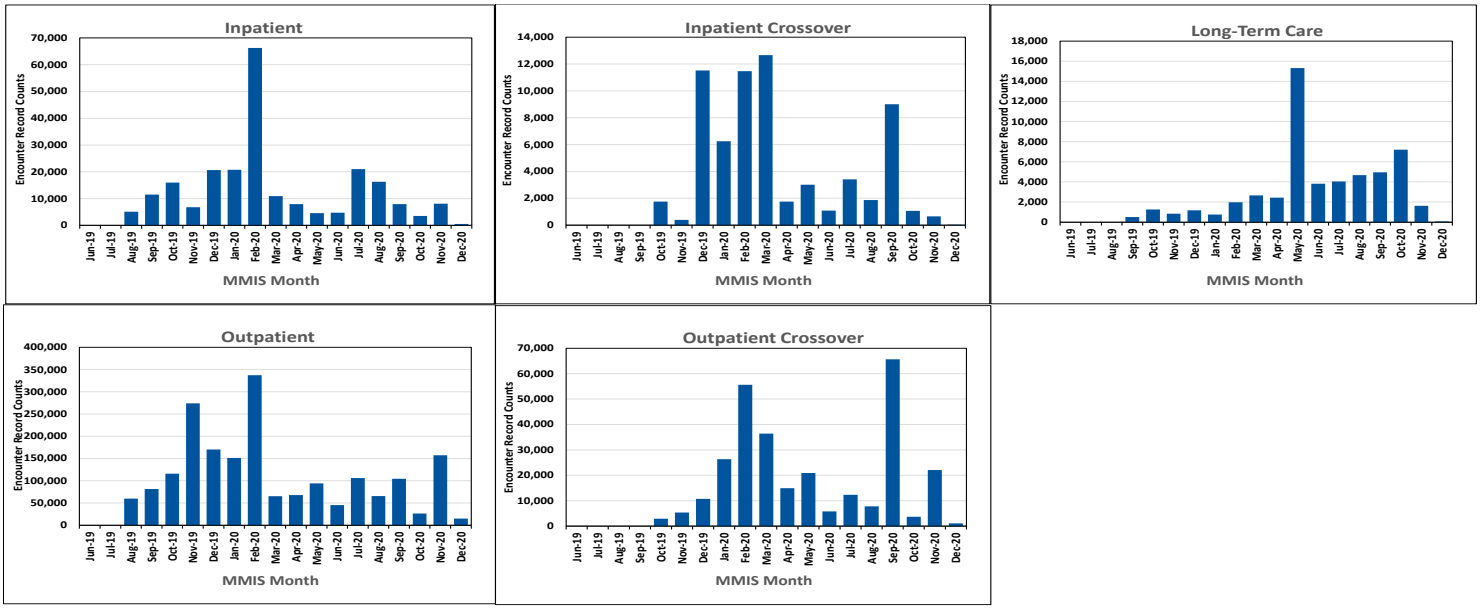
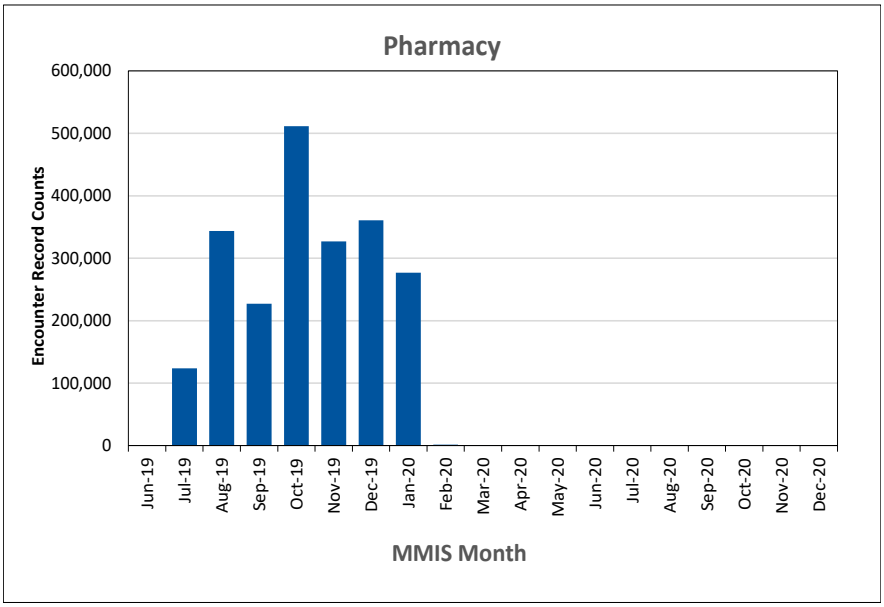


Figure 3-3—Pharmacy Encounter Record Counts by MMIS Month for ITC



The second measure to evaluate encounter data completeness is to evaluate unique visit/service counts by service month. Figure 3-4, Figure 3-5, and Figure 3-6 display the visit/service counts by service month and visit/service counts per 1,000 member months (MM) for professional encounters (i.e., HCFA-1500, Medicare Part B crossover, and waiver), institutional encounters (i.e., inpatient, inpatient crossover, long-term care, outpatient, and outpatient crossover), and pharmacy encounters, respectively.

Figure 3-4—Professional Encounter Visits and Encounter Visits per 1,000 MM By Category of Service for ITC

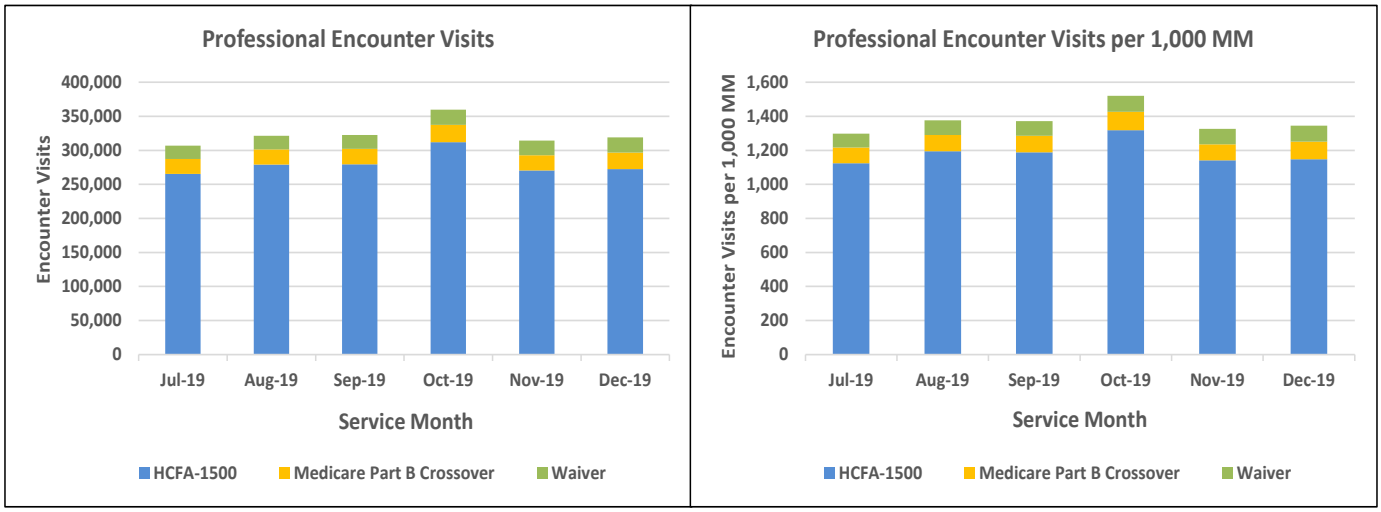


Figure 3-5—Institutional Encounter Visits and Encounter Visits per 1,000 MM By Category of Service for ITC

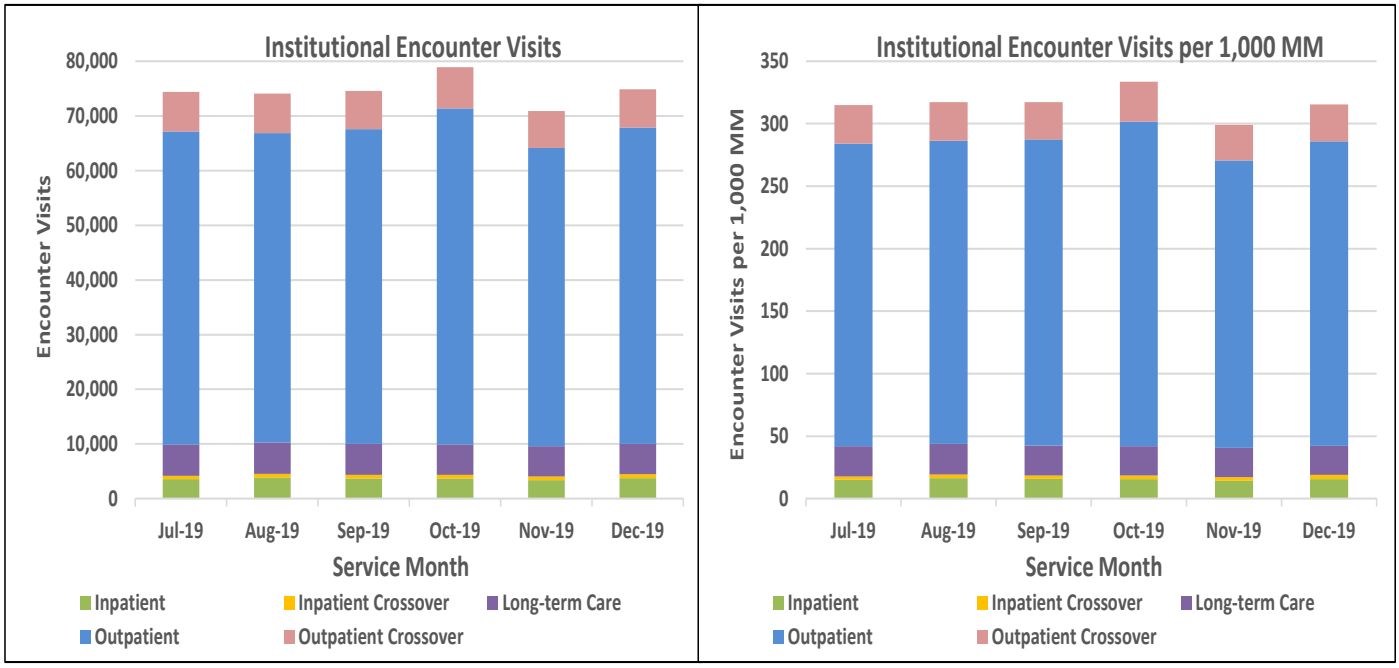
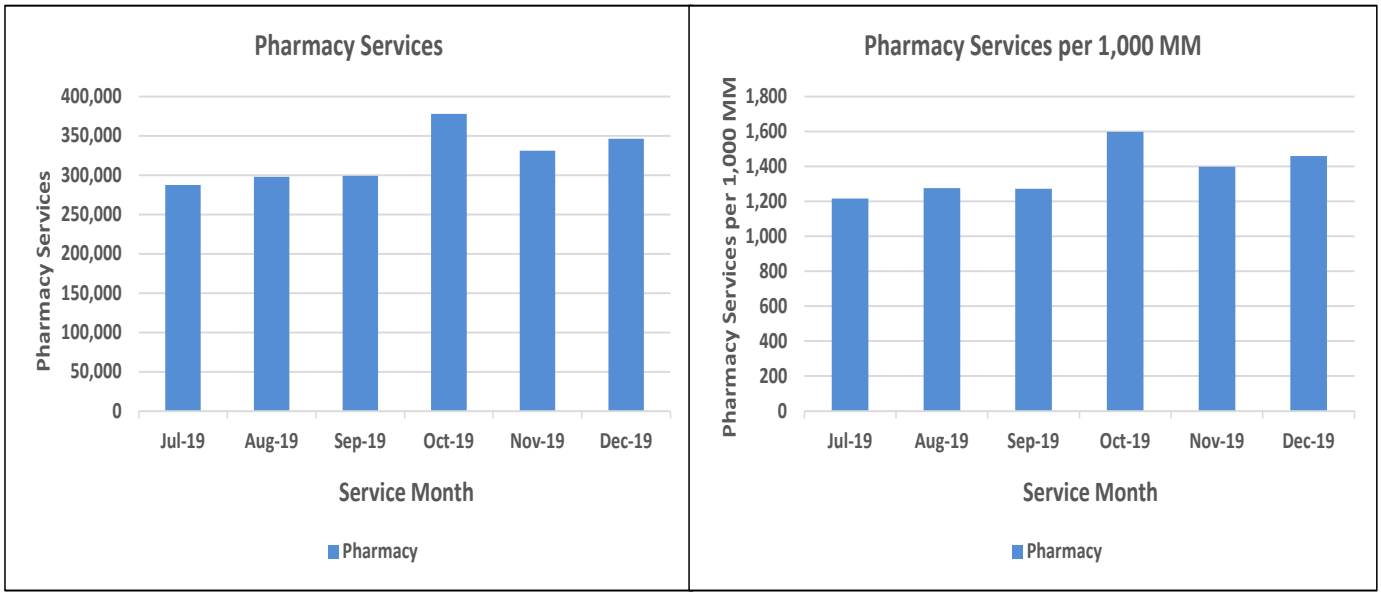


Figure 3-6—Pharmacy Services and Services per 1,000 MM for ITC



The final measure describes Iowa Total Care's encounter completeness based on paid amounts by service month. Figure 3-7, Figure 3-8, and Figure 3-9 display the paid amounts and paid amounts per member per month (PMPM) by service month for professional encounters (i.e., HCFA-1500, Medicare Part B crossover, and waiver), institutional encounters (i.e., inpatient, inpatient crossover, long-term care, outpatient, and outpatient crossover), and pharmacy encounters, respectively.

Figure 3-7—Professional Encounters Total Paid Amounts and Paid Amounts PMPM By Category of Service for ITC

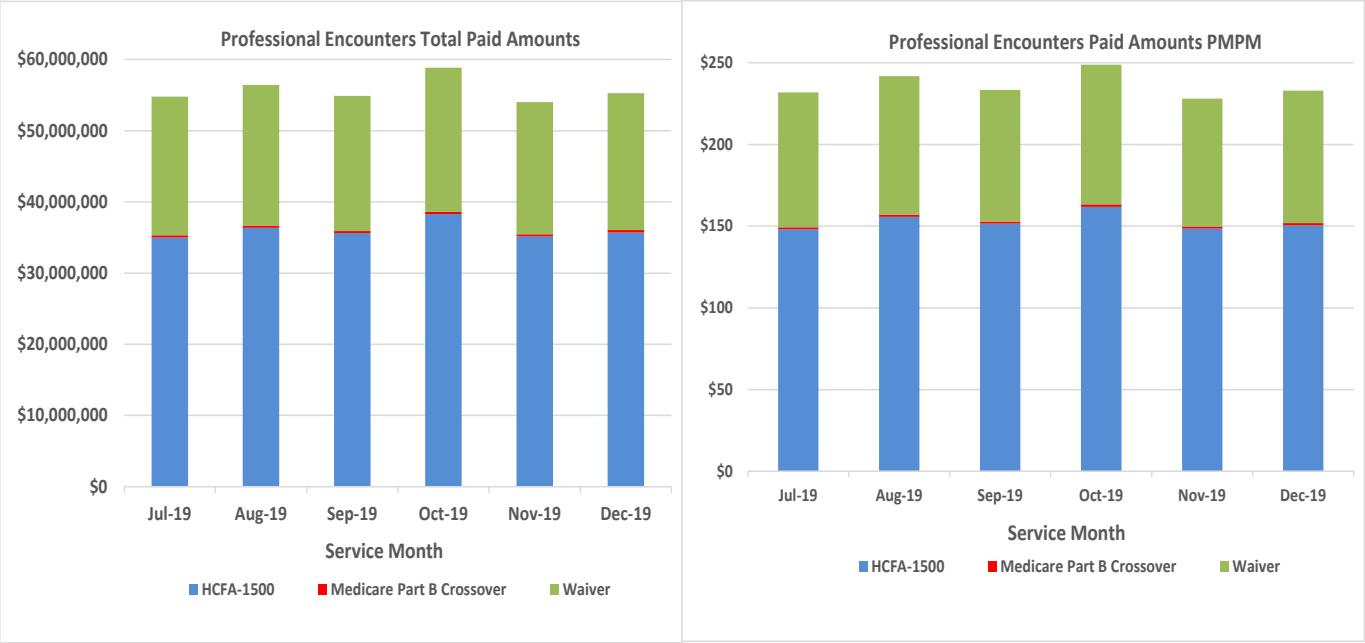


Figure 3-8—Institutional Encounters Total Paid Amounts and Paid Amounts PMPM By Category of Service for ITC

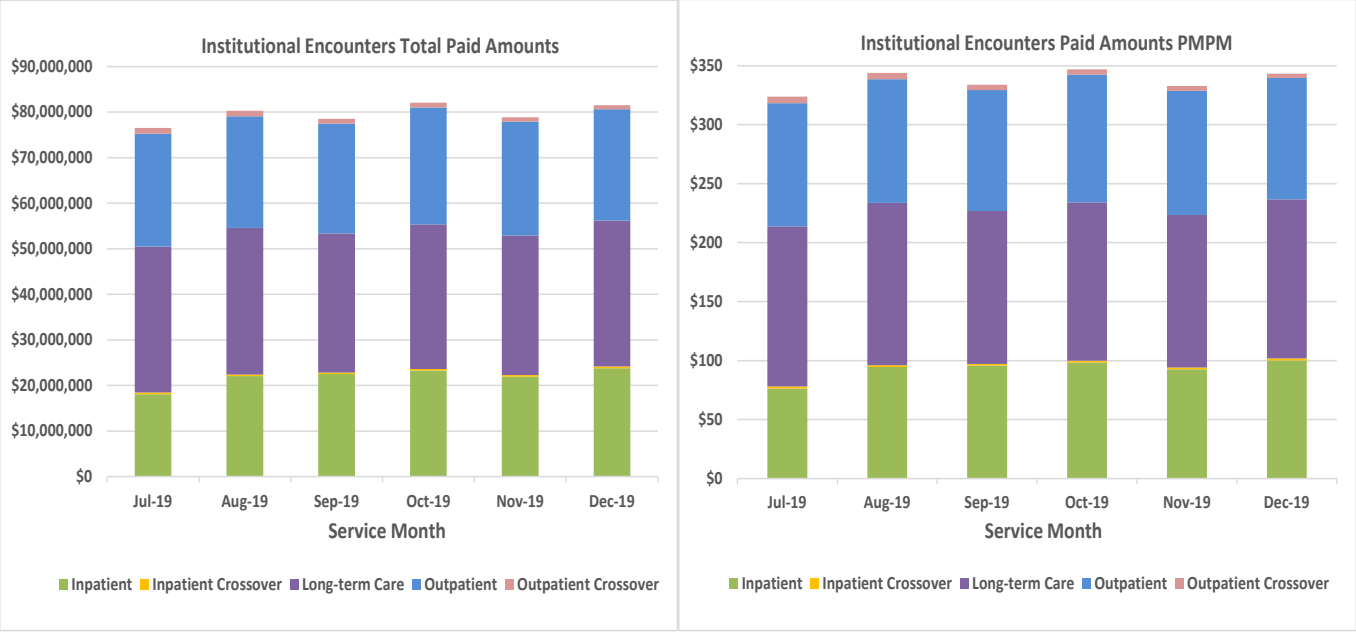
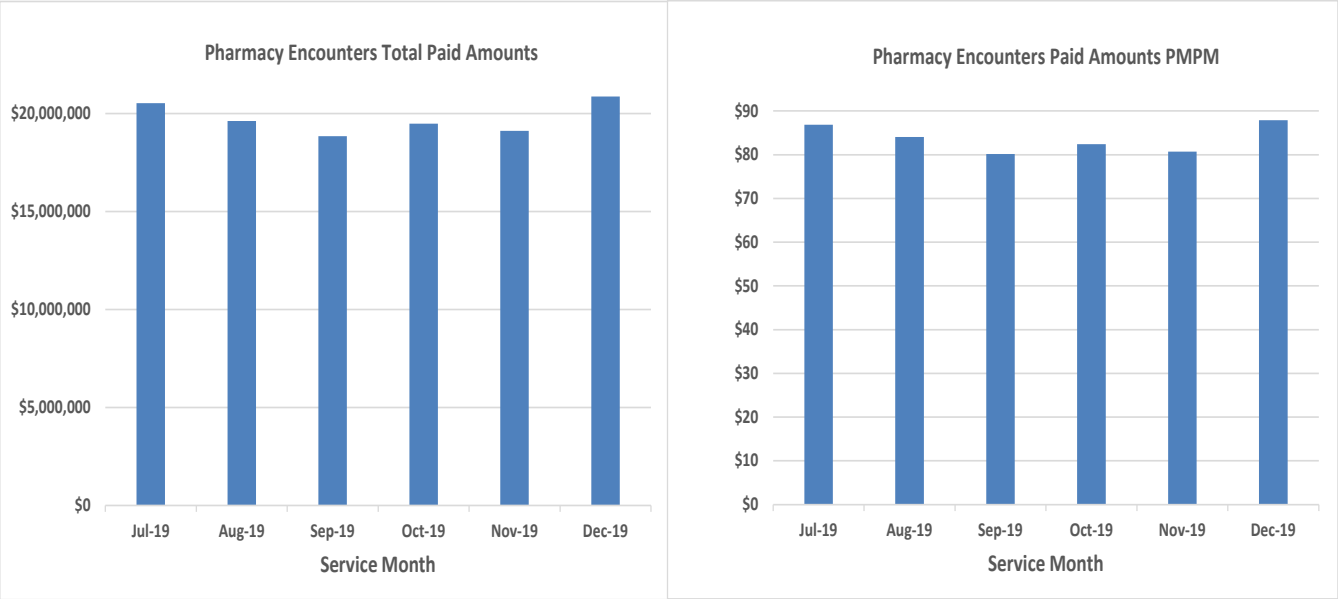


Figure 3-9—Pharmacy Encounters Total Paid Amounts and Paid Amounts PMPM for ITC



Encounter Data Timeliness

The first timeliness study indicator evaluates the lag between the date of service and the MMIS processed date. Figure 3-10, Figure 3-11, and Figure 3-12 display the cumulative percentage of records processed by MMIS within specified days from the dates of service by monthly intervals for professional encounters (i.e., HCFA-1500, Medicare Part B crossover, and waiver), institutional encounters (i.e., inpatient, inpatient crossover, long-term care, outpatient, and outpatient crossover), and pharmacy encounters, respectively.

Figure 3-10—Cumulative Percentage of Professional Encounters Accepted Into DHS' MMIS From Date of Service by Category of Service for ITC

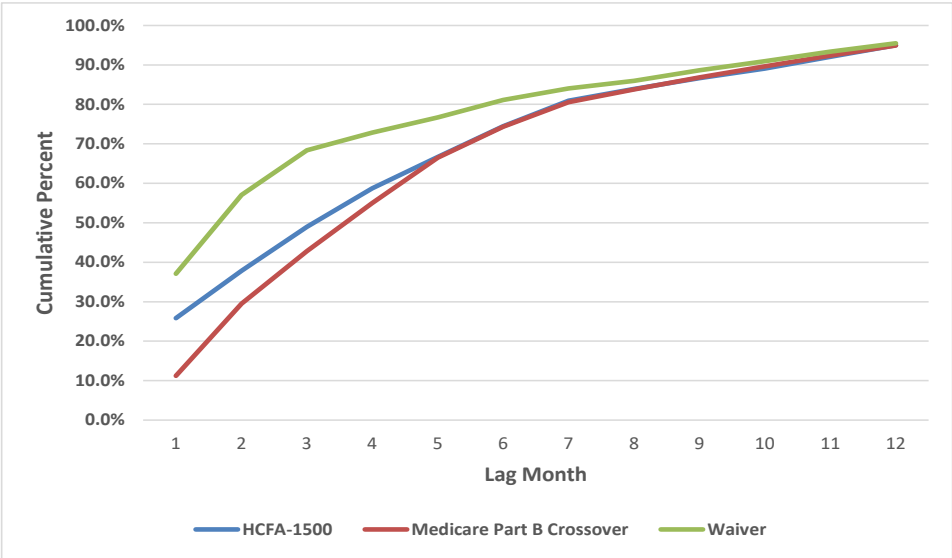


Figure 3-11—Cumulative Percentage of Institutional Encounters Accepted Into DHS' MMIS From Date of Service by Category of Service for ITC

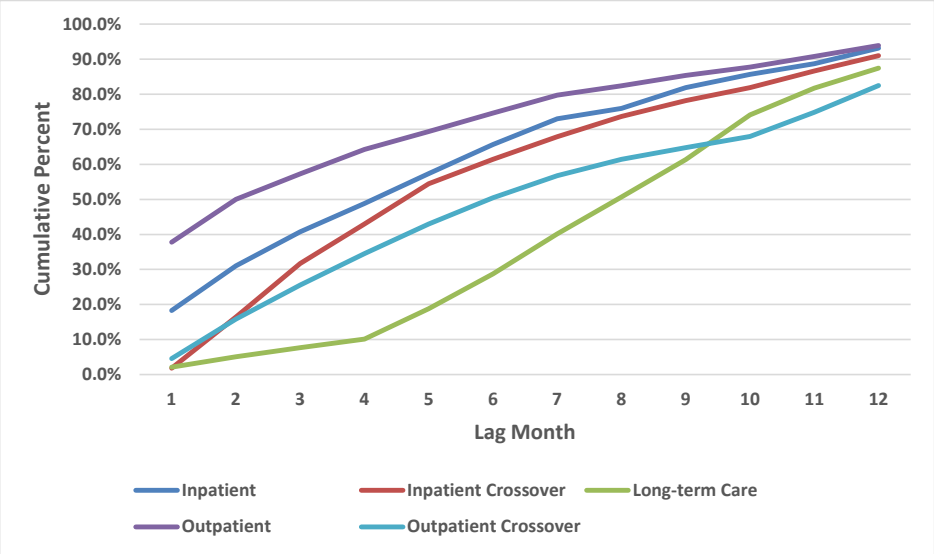
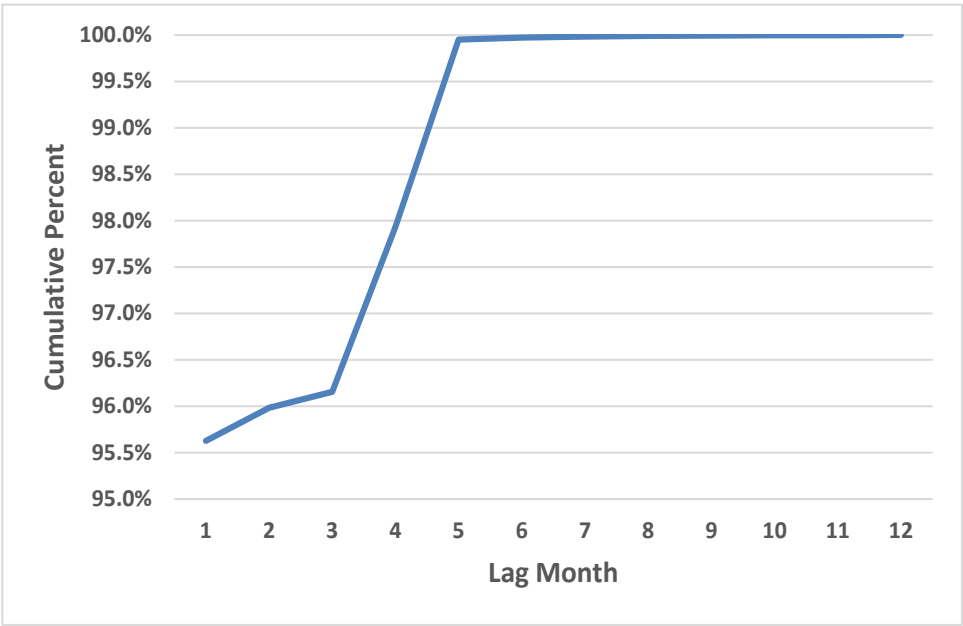


Figure 3-12—Cumulative Percentage of Pharmacy Encounters Accepted Into DHS' MMIS From Date of Service for ITC



The second timeliness measure evaluates the lag days between Iowa Total Care's paid date and the MMIS date. Figure 3-13, Figure 3-14, and Figure 3-15 display the cumulative percentage of records processed by MMIS within specified days from the payment date for professional encounters (i.e., HCFA-1500, Medicare Part B crossover, and waiver), institutional encounters (i.e., inpatient, inpatient crossover, long-term care, outpatient, and outpatient crossover), and pharmacy encounters, respectively.

Figure 3-13—Cumulative Percentage of Professional Encounters Accepted Into DHS' MMIS Since MCO Payment Date By Category of Service for ITC

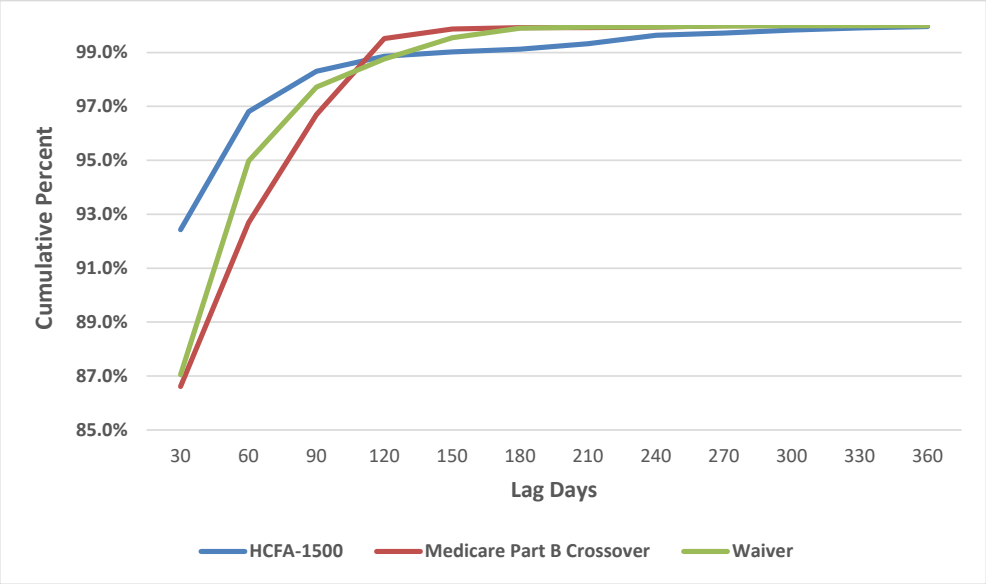


Figure 3-14—Cumulative Percentage of Institutional Encounters Accepted Into DHS' MMIS Since MCO Payment Date By Category of Service for ITC

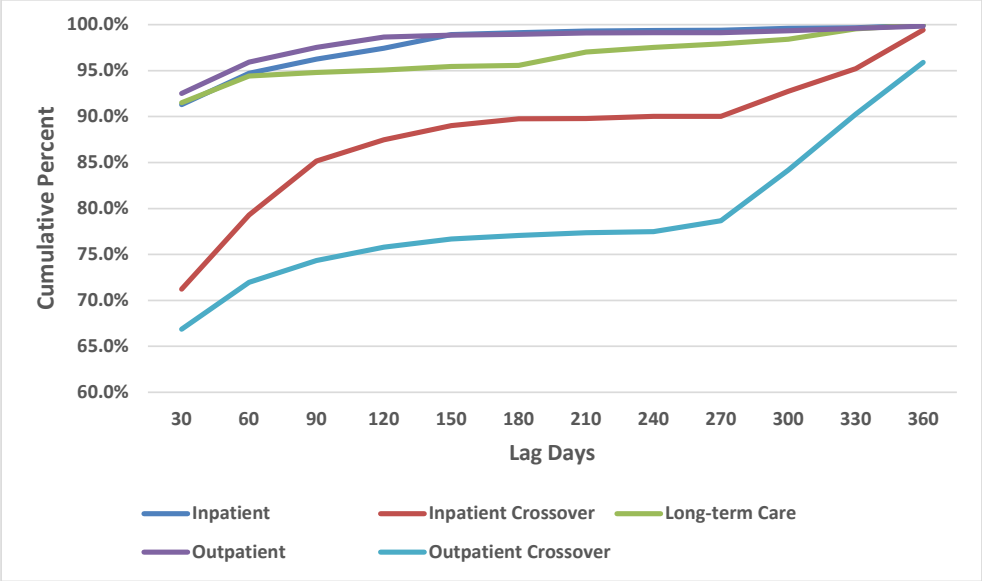
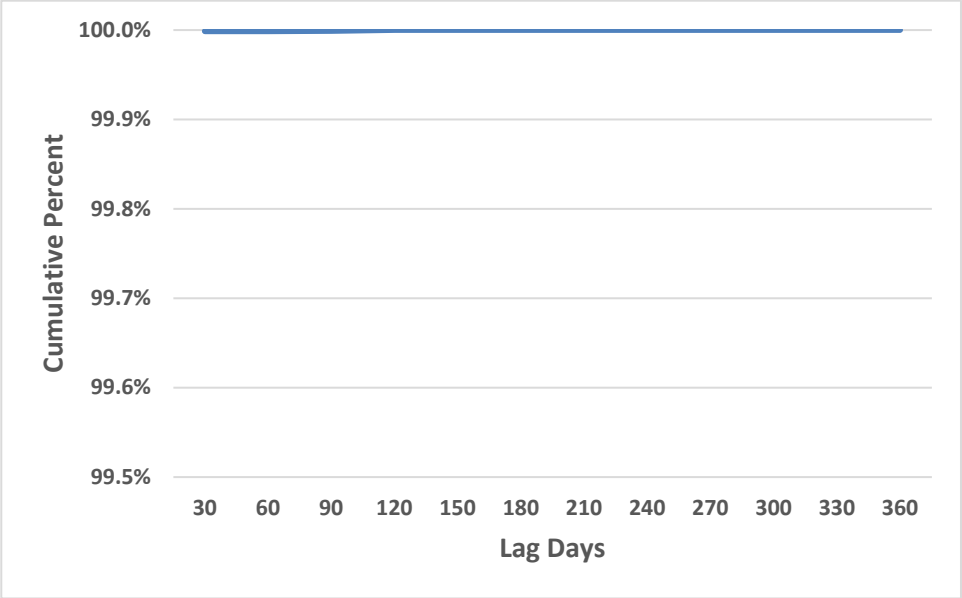


Figure 3-15—Cumulative Percentage of Pharmacy Encounters Accepted Into DHS' MMIS Since MCO Payment Date for ITC



Field-Level Encounter Data Completeness and Accuracy

HSAG evaluated key data elements to determine the completeness and accuracy of DHS' encounter data. Table 3-46, Table 3-47, and Table 3-48 display results for the key data elements for Iowa Total Care's professional encounters by category of service (i.e., HCFA-1500, Medicare Part B crossover, and waiver), institutional encounters (i.e., inpatient, inpatient crossover, long-term care, outpatient, and outpatient crossover), and pharmacy encounters, respectively.

Table 3-46—Professional Encounters Percentage of Present and Valid Values by Category of Service for ITC

Field	HCFA-1500		Medicare Part B Crossover		Waiver	
	Percent Present	Percent Valid Value	Percent Present	Percent Valid Value	Percent Present	Percent Valid Value
Member ID	100.0%	>99.9%	100.0%	>99.9%	100.0%	>99.9%
Detail First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Detail Last Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Paid Date	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Billing Provider NPI	>99.9%	99.5%	100.0%	99.7%	100.0%	100.0%
Rendering Provider NPI	>99.9%	99.5%	100.0%	99.8%	100.0%	>99.9%
Primary Diagnosis Code	100.0%	>99.9%	100.0%	>99.9%	100.0%	>99.9%
Secondary Diagnosis Code	47.5%	>99.9%	66.7%	>99.9%	5.8%	99.9%

Field	HCFA-1500		Medicare Part B Crossover		Waiver	
	Percent Present	Percent Valid Value	Percent Present	Percent Valid Value	Percent Present	Percent Valid Value
CDT/CPT/HCPCS Procedure Code(s)	100.0%	>99.9%	100.0%	>99.9%	100.0%	>99.9%
NDC	6.5%	98.3%	3.1%	96.7%	<0.01%	89.8%

Table 3-47—Institutional Encounters Percentage of Present and Valid Values by Category of Service for ITC

Field	Inpatient		Inpatient Crossover		Long-term Care		Outpatient		Outpatient Crossover	
	Percent Present	Percent Valid Value	Percent Present	Percent Valid Value	Percent Present	Percent Valid Value	Percent Present	Percent Valid Value	Percent Present	Percent Valid Value
Member ID	100.0%	99.7%	100.0%	99.7%	100.0%	>99.9%	100.0%	>99.9%	100.0%	>99.9%
Header First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Paid Date	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Billing Provider NPI	100.0%	99.9%	100.0%	>99.9%	100.0%	100.0%	100.0%	>99.9%	100.0%	>99.9%
Attending Provider NPI	>99.9%	99.5%	100.0%	99.8%	>99.9%	>99.9%	>99.9%	99.2%	99.9%	99.7%
Primary Diagnosis Code	100.0%	>99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%
Secondary Diagnosis Code	83.6%	100.0%	93.5%	100.0%	69.5%	>99.9%	64.4%	>99.9%	76.4%	>99.9%
Primary Surgical Procedure Code	33.5%	100.0%	20.4%	100.0%	0.0%	NA	<0.01%	0.0%	0.0%	NA
Secondary Surgical Procedure Code	19.0%	100.0%	12.2%	100.0%	0.0%	NA	0.0%	NA	0.0%	NA
CDT/CPT/HCPCS Procedure Code(s)	6.8%	99.8%	48.5%	98.0%	17.3%	97.3%	92.5%	>99.9%	92.5%	>99.9%
DRG	79.3%	91.8%	47.9%	79.6%	<0.01%	50.0%	0.0%	NA	0.0%	NA
Revenue Code	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
NDC	0.6%	95.8%	0.5%	95.5%	0.0%	NA	10.8%	97.3%	15.1%	96.8%

Table 3-48—Pharmacy Encounters Percentage of Present and Valid Values for ITC

Field	Percent Present	Percent Valid Value
Member ID	100.0%	>99.9%
Date of Service	100.0%	>99.9%
Paid Date	100.0%	>99.9%

Field	Percent Present	Percent Valid Value
Billing Provider NPI	100.0%	100.0%
Prescribing Provider NPI	>99.9%	99.8%
NDC	100.0%	>99.9%

Strengths, Weaknesses, and Recommendations—CY 2020 Administrative Profile Analysis

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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: The distribution for the record counts by MMIS month for most services generally conformed to a bell- or trapezoid-shaped curve for record counts by MMIS month, with the exception of a few months that deviated from these general shapes. A bell-shaped or trapezoid-shaped distribution is ideal for encounter data record counts as it indicates that the MCO's encounter data submissions were generally consistent. [**Quality** and **Timeliness**]

Strength #2: The visit/service counts by service month for all services within each of the encounter types were relatively stable over time. This observation indicates that the encounter data volume was relatively complete. Similarly, the trends for the paid amount by service month for all services within each of the encounter types generally showed a similar trend to those for the visit/service counts by service month. [**Quality**]

Strength #3: For each of the services within the professional, institutional, and pharmacy encounters, Iowa Total Care was generally timely in submitting encounters to DHS, with very few exceptions. [**Timeliness**]

Strength #4: All key data elements within the professional, institutional, and pharmacy encounters had percent valid rates of nearly or 100.0 percent, with very few exceptions. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There were a few key data fields that did not have high valid value rates (e.g., NDC and DRG values). [**Quality**]

Why the weakness exists: The NDC data element had percent valid values of 95.8 percent and 95.5 percent for inpatient and inpatient crossover services, respectively. For the outpatient and outpatient crossover services, the percent valid value was 97.3 percent each. The DRG data element had percent valid values of 91.8 percent, 79.6 percent, and 50.0 percent for inpatient, inpatient crossover, and long-term care services, respectively.

Recommendation: HSAG recommends that DHS discuss the field(s) values with Iowa Total Care to understand the root cause(s).

Performance Results—CY 2021: Comparative Analysis

There are two aspects of record completeness—record omission and record surplus. Table 3-49 displays the percentage of records present in the files submitted by Iowa Total Care that were not found in the DHS-submitted files (record omission), and the percentage of records present in the DHS-submitted files but not present in Iowa Total Care-submitted files (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 3-49—Record Omission and Surplus Rates for ITC

Encounter Type	Omission	Surplus
Professional	5.0%	5.3%
Institutional	10.0%	0.5%
Pharmacy	9.6%	0.0%

Table 3-50 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the professional encounters for Iowa Total Care. For the element omission and surplus indicators, lower rates indicate better performance; while for element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 3-50—Data Element Omission, Surplus, Absent, and Accuracy: Professional Encounters for ITC

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Member ID	0.0%	0.0%	0.0%	>99.9%
Detail Service From Date	0.0%	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	0.0%	>99.9%
Billing Provider NPI	0.0%	3.2%	<0.1%	99.6%
Rendering Provider NPI	0.0%	40.7%	<0.1%	>99.9%
Referring Provider NPI[A]	2.2%	<0.1%	58.3%	>99.9%
Primary Diagnosis Code	0.0%	<0.1%	0.0%	92.5%
Secondary Diagnosis Code[A]	<0.1%	12.2%	51.0%	92.1%
Procedure Code	0.0%	<0.1%	0.0%	>99.9%
Procedure Code Modifier[A]	<0.1%	<0.1%	55.9%	>99.9%
Units of Service	0.0%	0.0%	0.0%	99.6%
NDC[A]	<0.1%	0.0%	94.2%	100.0%
Detail Paid Amount	0.0%	0.0%	0.0%	99.9%

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

Table 3-51 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the institutional encounters for Iowa Total Care. For the element omission and surplus indicators, lower rates indicate better performance; while for element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 3-51—Data Element Omission, Surplus, Absent, and Accuracy: Institutional Encounters for ITC

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Member ID	0.0%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	0.0%	>99.9%
Admission Date[A]	0.0%	0.0%	74.3%	>99.9%
Billing Provider NPI	0.0%	0.6%	0.0%	>99.9%
Attending Provider NPI	0.0%	0.0%	0.1%	100.0%
Referring Provider NPI[A]	0.1%	0.4%	97.4%	100.0%
Primary Diagnosis Code	0.0%	0.0%	0.0%	>99.9%
Secondary Diagnosis Code[A]	<0.1%	<0.1%	17.7%	>99.9%
Procedure Code[A]	0.0%	0.0%	18.1%	100.0%
Procedure Code Modifier[A]	<0.1%	<0.1%	77.8%	>99.9%
Units of Service	0.0%	0.0%	0.0%	85.6%
Primary Surgical Procedure Code[A]	1.6%	0.0%	93.9%	100.0%
Secondary Surgical Procedure Code[A]	1.1%	0.0%	96.2%	99.8%
NDC[A]	<0.1%	<0.1%	90.2%	99.3%
Revenue Code	0.0%	0.0%	0.0%	100.0%
DRG Code[A]	<0.1%	0.2%	90.1%	<0.1%
Header Paid Amount	0.0%	0.0%	0.0%	99.6%
Detail Paid Amount	0.0%	0.0%	0.0%	99.5%

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

Table 3-52 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the pharmacy encounters for Iowa Total Care. For the element omission and surplus indicators, lower rates indicate better performance, while for element accuracy indicator higher rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 3-52—Data Element Omission, Surplus, Absent, and Accuracy: Pharmacy Encounters for ITC

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Member ID	0.0%	0.0%	0.0%	99.9%
Header Service From Date	0.0%	0.0%	0.0%	100.0%
Billing Provider NPI	0.0%	0.0%	0.0%	99.9%

Key Data Elements	Element Omission	Element Surplus	Element Absent	Element Accuracy
Prescribing Provider NPI	<0.1%	0.0%	0.0%	>99.9%
NDC	0.0%	0.0%	0.0%	99.8%
Drug Quantity	0.0%	0.0%	0.0%	96.2%
Header Paid Amount	0.0%	0.0%	0.0%	100.0%
Dispensing Fee	0.0%	0.0%	0.0%	100.0%

Table 3-53 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing or non-missing) for all key data elements relevant to each encounter data type for Iowa Total Care. Of note, an adjustment was made in calculating the all-element accuracy indicator for professional encounters. For professional encounters, while the *Rendering Provider NPI* data element was included in the individual data element assessment (i.e., element omission, element surplus, and element accuracy), this data element was not included in the calculation of the all-element accuracy rate. This is due to the knowledge that the way this data element was processed and populated in DHS' MMIS deviated from how the values were submitted by the MCOs to DHS. For the all-element accuracy indicator, higher rates indicate better performance.

Table 3-53—All-Element Accuracy and Encounter Type for ITC

Professional Encounters	Institutional Encounters	Pharmacy Encounters
46.3%	96.4%	95.8%

Strengths, Weaknesses, and Recommendations—CY 2021 Comparative Analysis

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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: The record surplus rates for institutional and pharmacy encounters were very low at 0.5 percent and 0.0 percent, respectively, suggesting that nearly all of the encounters in DHS-submitted data were corroborated in the Iowa Total Care data. [**Quality**]

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

Strength #3: Among encounters that could be matched between the DHS data warehouse and Iowa Total Care's data system, a high level of element accuracy (i.e., data elements from both sources had the same values) was exhibited, with very few exceptions. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The record omission and record surplus rates for professional encounters were moderately high at 5.0 percent and 5.3 percent, respectively. [**Quality**]

Why the weakness exists: Based on Iowa Total Care's investigation of the discrepant omission records, for vision encounters it included voided and corrected encounters when it should have only included the corrected encounters. For the discrepant surplus records, Iowa Total Care determined that the Internal Control Number values provided by its transportation vendor were incorrect.

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

Weakness #2: Iowa Total Care's surplus rate for the data element Secondary Diagnosis Code was high at 12.2 percent. The accuracy rates for the data elements Primary Diagnosis Code and Secondary Diagnosis Code were low with rates of 92.5 percent and 92.1 percent, respectively. [**Quality**]

Why the weakness exists: Based on Iowa Total Care's investigation of the discrepant records, it noted that for vision claims, the primary and secondary diagnosis codes were transposed incorrectly on the data extract for the study. For medical claims, Iowa Total Care noted that the diagnosis code values reported in the extract for the study were incorrect due to differences in how the diagnosis codes were sourced for the creation of the data extract.

Recommendation: HSAG recommends that Iowa Total Care implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. Iowa Total Care noted that process modifications were underway to ensure diagnosis codes are reported correctly.

Weakness #3: Iowa Total Care's accuracy rate for the data element DRG code was very low at less than 0.1 percent.

Why the weakness exists: Iowa Total Care had been submitting the DRG code value to DHS with a leading zero followed by a three-digit value. Consequently, when these values were collected and stored within DHS' MMIS as a three-digit DRG code value, the fourth digit was consistently truncated. Similarly, the Iowa Total Care-submitted data for the study also included DRG code values with a leading zero followed by a three-digit value. Prior to conducting the analysis, HSAG first stripped the leading zero from the Iowa Total Care-submitted DRG code value and compared the last three-digit value to DHS' three-digit DHS-submitted DRG code value. Since the DHS-submitted DRG values contained the leading zero, the comparison between the two sources of data resulted in a very low match rate.

Recommendation: DHS is aware of the DRG submission issue and is working with Iowa Total Care to remedy the issue. As such, HSAG recommends that Iowa Total Care continue to work with DHS to ensure the issue has been corrected and that moving forward, the values are complete and accurate.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-54 presents Iowa Total Care's 2021 adult Medicaid and general child Medicaid CAHPS top-box scores.[3-4] Arrows (↓ or ↑) indicate 2021 scores that were at least 5 percentage points higher or lower than the 2020 national average.

Table 3-54—Summary of 2021 CAHPS Top-Box Scores for ITC

	2021 Adult Medicaid	2021 General Child Medicaid
Composite Measures		
Getting Needed Care	88.8% ↑	NA
Getting Care Quickly	89.3% ↑	NA
How Well Doctors Communicate	96.3%	96.4%
Customer Service	NA	NA
Global Ratings		
Rating of All Health Care	60.8%	73.9%
Rating of Personal Doctor	78.4% ↑	80.8%
Rating of Specialist Seen Most Often	65.0%	NA
Rating of Health Plan	66.9%	69.6%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	NA	
Discussing Cessation Medications	NA	
Discussing Cessation Strategies	NA	

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 deviate from NCQA's methodology of calculating a rolling two-year average, since only one year of CAHPS data are available.

↑ Indicates the 2021 score is at least 5 percentage points greater than the 2020 national average.

↓ Indicates the 2021 score is at least 5 percentage points less than the 2020 national average.

Indicates that the measure does not apply to the population.

[3-4] ITC administered the CAHPS 5.1H Child Medicaid Health Plan Survey without the CCC measurement set; therefore, results for the CCC Medicaid population are not available and cannot be presented.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the results for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity results 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: Adult members had positive experiences with getting needed care and getting care quickly since the scores for the *Getting Needed Care* and *Getting Care Quickly* measures were at least 5 percentage points greater than the 2020 NCQA Medicaid national averages. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Adult members had positive experiences with their personal doctor since the score for the *Rating of Personal Doctor* measure was at least 5 percentage points greater than the 2020 NCQA Medicaid national average. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

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

Why the weakness exists: No significant weaknesses were identified; therefore, this section is not applicable.

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

Quality Rating

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

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

To identify strengths and weaknesses and draw conclusions for Iowa Total Care about the quality, timeliness, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by Iowa Total Care across all EQR activities to identify common themes within Iowa Total Care that impacted, or will have the likelihood to impact, member health outcomes. The overarching aggregated findings show that Iowa Total Care members had access to many services, which could be related to the use of telehealth, and this was corroborated through higher member experience ratings for the *Getting Needed Care* and *Getting Care Quickly* CAHPS measures.

Iowa Total Care also demonstrated an adequate network of providers to provide services to its members, and had effective processes, procedures, and monitoring efforts in place to continually evaluate its provider network for necessary network enhancements as determined through high performance in the Availability of Services and Assurances of Adequate Capacity and Services compliance review standards.

However, performance measures representing services that were not available via telehealth due to the nature of requiring physical examination and/or lab work, such as *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—Blood Glucose and Cholesterol Testing*, and *Comprehensive Diabetes Care* demonstrated performance below the national Medicaid 25th percentile. Additionally, even though Iowa Total Care appeared to have an adequate network for all of its members, the adult population was not always accessing services in a timely manner to obtain the preventive and/or condition-specific care they needed to maintain optimal health, as indicated through lower-performing HEDIS measure rates in the Access to Preventive Care, Women's Health, and Living With Illness domains. Specifically, all seven indicators within the Access to Preventive Care domain, four of the five nationally comparable rates within the Women's Health domain, and all four nationally comparable rates within the Living With Illness domain performed below the national Medicaid 50th percentile, indicating opportunities to improve the prevalence of timely access to services (specifically for adult members) in those measure domains. Five of 15 indicators within the Medication Management domain also performed below the national Medicaid 50th percentile, suggesting that both child and adult members may have experienced barriers accessing care, or Iowa Total Care's providers were not effectively treating members' conditions through appropriate medication management. Iowa Total Care should assess whether inappropriate medication management is related to member visit noncompliance or whether the prescribing patterns (or lack thereof) were related to provider quality of care issues. Improvement in medication management should demonstrate overall improvement in member health outcomes, especially for those members with chronic conditions. Additionally, although Iowa Total Care continued its *Timeliness of Postpartum Care* PIP in CY 2021, the *Prenatal and Postpartum Care—Postpartum Care* HEDIS measure indicator rate was below the national Medicaid 50th percentile. However, Iowa Total Care had not progressed to implementing interventions for its PIP; therefore, performance in this area is expected to improve in future years.

Although potential concerns were identified with member access to preventive and specialty care, access to behavioral health treatment was an exception. Iowa Total Care's performance under the Behavioral Health domain ranked at or above the 90th percentile for four of the 12 indicators: *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up* and *30-Day Follow-Up*, and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* and *Engagement of AOD Treatment*. Iowa Total Care's performance also ranked between the 75th and 89th percentiles for *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*. Iowa Total Care also performed strongly in the Coordination and Continuity of Care compliance review standard, suggesting that performance for these behavioral health performance measure indicators may have been positively impacted by effective care coordination processes to ensure that members were getting the care they needed, especially after treatment for behavioral health conditions, and that Iowa Total Care

was committed to improving physical and mental function and reducing repeat ED visits, hospital readmissions, and healthcare spending. Additionally, due to the addition of telehealth services to the MY 2020 measure specifications, performance at or above the national Medicaid 75th percentile for these indicators suggests a high adoption rate for telehealth services during the COVID-19 pandemic, which was also supported by the NAV activity indicating that one in five Iowa Total Care members used telehealth services in CY 2020.

As Iowa Total Care assesses its performance over the past CY, it should consider how telehealth services can be further leveraged to support improved member outcomes. Iowa Total Care should specifically consider whether it can promote the use of telehealth for services that were not being accessed by members when necessary, including visits for medication management, such as for children prescribed ADHD medications or adults taking an antidepressant medication.

Of note, due to the COVID-19 pandemic during HEDIS MY 2020 and SFY 2021, many preventive services were negatively affected across the country as states followed orders to reduce the use of nonemergent services in order to slow the spread of coronavirus disease. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have impacted performance outcomes in SFY 2021.

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

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2021 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 DHS' network adequacy standards) and §438.206 (adherence to DHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the PAHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in CY 2021 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, refer to Appendix A.

Performance Improvement Projects

For the CY 2021 validation, the PAHPs continued their DHS-mandated PIP topics that were initiated in CY 2018, reporting Remeasurement 2 study indicator outcomes. Table 4-1 outlines the selected PIP topics and study indicators for the PAHPs.

Table 4-1—PIP Topics and Study Indicators

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

Performance Measure Validation

DHS identified a set of performance measures, as shown in Table 4-2, that the PAHPs were required to calculate and report. These measures were required to be reported following the measure specifications provided by DHS. DHS identified the measurement period as July 1, 2020, through June 30, 2021.

Table 4-2—List of Performance Measures for PAHPs

2021 Performance Measures Selected by DHS for Validation		
Measure Name	**Method**	**Steward**
Members With at Least Six Months of Coverage	Administrative	DHS
Members Who Accessed Dental Care	Administrative	DHS
Members Who Received Preventive Dental Care	Administrative	DHS
Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation	Administrative	DHS
Members Who Received an Oral Evaluation During the Measurement Year, Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation, and Received an Oral Evaluation 6–12 Months Prior to the Oral Evaluation	Administrative	DHS
Members Who Received a Preventive Examination and a Follow-Up Examination	Administrative	DHS

Additionally, DHS has established a quality withhold payment structure intended to incentivize the PAHPs to achieve high-quality care for their members. This quality withhold program includes six performance levels for *Access to Dental Services*, *Access to Preventive Dental Services*, and *Continued Preventive Utilization* performance measures. The PAHPs are eligible to receive up to 2 percent of their

premium in a quality withhold payment, based on reaching the highest performance level in all three measures, with *Access to Dental Services*, *Access to Preventive Dental Services*, and *Continued Preventive Utilization* constituting 50 percent, 30 percent, and 20 percent of the withhold, respectively.

Compliance Review

CY 2021 commenced a new three-year cycle of compliance reviews. The compliance reviews for the DHS-contracted PAHPs comprise 14 program areas, referred to as standards, that correlate to the federal standards and requirements identified in 42 CFR §438.358(b)(1)(iii). These standards also include applicable State-specific contract requirements and areas of focus identified by DHS. For CY 2021, HSAG conducted a review of seven standards, as identified in Table 4-3 under Year One. Table 4-3 also delineates the compliance review activities, and standards reviewed, in year two and year three of the three-year cycle.

Table 4-3—Three-Year Cycle of Compliance Reviews

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

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

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

Readiness Review

Effective July 1, 2021, DHS transitioned the administration of children's Medicaid dental benefits (DWP Kids) from an FFS program to a managed care program. DHS requested that HSAG conduct a readiness review of the existing PAHPs in key program areas noted in 42 CFR §438.66(d)(4) and displayed presented in Table 4-4 below. The CY 2021 compliance review activity and readiness review activity occurred simultaneously; therefore, HSAG used the results of the compliance review to supplement findings for the readiness review in overlapping program areas. Table 4-4 also identifies program areas in which DHS maintained responsibility for assessing the PAHPs' readiness, and these program areas were not part of the readiness review performed by HSAG.

Table 4-4—Federal Readiness Review Areas

Federal Readiness Review Areas	Responsible Entity	
	HSAG	DHS
Operations/Administration		
Administrative Staffing and Resources	✓	
Delegation and Oversight	✓	
Member and Provider Communications	✓	
Grievance and Appeals	✓	
Member Services and Outreach	✓	
Provider Network Management	✓	
Program Integrity/Compliance		✓
Service Delivery		
Case Management/Care Coordination/Service Planning	✓	
Quality Improvement	✓	
Utilization Review	✓	
Financial Management		
Financial Reporting and Monitoring		✓
Financial Solvency		✓
Systems Management*		
Claims Management and Encounter Data*	✓	✓

* While DHS maintained responsibility for assessing the PAHPs' readiness as it relates to systems management, HSAG's readiness included a high-level assessment of each PAHP's enrollment information, and encounter data and claims management.

Network Adequacy Validation

For the CY 2021 network adequacy validation activity, HSAG conducted a dental provider network disruption analysis. The purpose of the network disruption analysis was to evaluate whether DWP Kids members had adequate access to dental provider services after the transition of dental services from the FFS program to the managed care program to ensure these services were available through one of the dental PAHPs.

The analysis evaluated the following indicators of disruption to the provider networks:

- Comparison between providers historically used by members through FFS and providers contracted with the new PAHP networks, including the extent of the overlap and services provided by providers available in FFS, but not in the PAHP networks
- Calculation of the change in average time and distance to reach the nearest provider for members whose providers were no longer in their provider network
- Comparison of the number of providers accepting new patients in the FFS network and the PAHPs' provider networks

Encounter Data Validation

HSAG conducted an administrative profile analysis of DHS' electronic encounter data. The goal of the study was to examine the accuracy, completeness, and timeliness of DHS' encounter data with service dates from July 1, 2019, to June 30, 2020. The degree of data completeness and accuracy among the PAHPs provided insight into the quality of DHS' overall encounter data system and represented the basis for establishing confidence in reporting and rate setting activities. The administrative analysis included the following key steps:

- Development of data submission requirements document for DHS.
- Conducting the administrative profile analysis.

HSAG evaluated specific metrics for encounter data completeness, encounter data timeliness, and field-level encounter data completeness and accuracy.

EQR Activity Results

Delta Dental of Iowa

Performance Improvement Projects

Performance Results

Table 4-5 displays the overall validation status, the baseline and remeasurement results, and the PAHP-designated goals for each study indicator.

Table 4-5—Overall Validation Rating for DDIA

PIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Annual Dental Visits	*Not Met*	1. The percentage of Medicaid members 19 years of age and older who had at least one dental visit during the measurement year.	44.2%	42.2% ↓	33.7% ↓	47.7%
		2. The percentage of Hawki members 1 to 18 years of age who had at least one preventive dental visit during the measurement year.	73.3%	72.3% ↓	59.9% ↓	76.5%

R1 = Remeasurement 1
R2 = Remeasurement 2 (to be included in CY 2021 annual assessment)
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

Table 4-6 displays the interventions implemented to address the barriers identified by the PAHP using QI and causal/barrier analysis processes.

Table 4-6—Remeasurement 2 Interventions for DDIA

Intervention Descriptions	
Sent text message reminders to members who had completed a preventive visit but had not completed the self-assessment. Sent voicemails, text messages, and postcards to Hawki members during Children's Dental Health month.	Sent postcards and text messages to members who had not received dental services within five months of enrollment. Sent text messages to guardians of members ages 15, 16, and 17 years who have a claim on file within the last 24 months.
Sent postcards and text messages to members 19 to 20 years of age.	Mailed flyers, toothbrushes, toothpaste, and floss to all pregnant women and members who self-attested to having diabetes.
Conducted outreach calls to a subset of members with no dental claim on file in the prior year.	Sent communications to members addressing office safety protocols to encourage scheduling routine care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Delta Dental of Iowa designed a methodologically sound improvement project. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Delta Dental of Iowa met 56 percent of the requirements for data analysis and implementation of improvement strategies, indicating that the PAHP may not have a complete understanding of all factors impacting members' ability to access dental services. [**Quality**, **Timeliness**, and **Access**]

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

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

Weakness #2: Delta Dental of Iowa demonstrated a decrease in the percentage of members with a dental visit for both study indicators during the second remeasurement period. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The decreased performance could be related to the overall decline in accessing routine dental care observed nationally because of the COVID-19 pandemic. However, Delta Dental of Iowa also implemented passive interventions, such as member text messages and postcards, which are difficult to evaluate for effectiveness and may not impact the study indicator outcomes.

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

Performance Measure Validation

Performance Results

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

concerns with any of the cases reviewed during PSV. HSAG determined that Delta Dental of Iowa's data integration and measure reporting processes were adequate and ensured data integrity and accuracy.

Table 4-7 displays measure designations and reportable measure rates. Delta Dental of Iowa received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 4-7—Performance Measure Designation and Rates for DDIA

Performance Measure		2019 Rate	2020 Rate	2021 Measure Designation	2021 Results		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	212,825	220,844	*R*	246,053	—	—
2	*Members Who Accessed Dental Care*	38.70%	34.15%	*R*	246,053	76,191	30.97%
3	*Members Who Received Preventive Dental Care*	79.0%	75.10%	*R*	76,191	57,516	75.49%
4	*Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation*	51,474	45,146	*R*	48,653	—	—
5	*Members Who Received an Oral Evaluation During the Measurement Year, Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation, and Received an Oral Evaluation 6–12 Months Prior to the Oral Evaluation*	32,537	29,326	*R*	—	26,657	—
6	*Members Who Received a Preventive Examination and a Follow-Up Examination*	63.2%	64.96%	*R*	48,653	26,657	54.79%

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity have been linked to and impacted one or more of these domains. If a domain is not associated with an

identified strength or weakness, the findings did not determine significant impact to quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Delta Dental of Iowa closely monitored performance of the preventive measures to identify opportunities for improvement through outreach campaigns. Delta Dental of Iowa monitored measure rates monthly and used the data on members missing services to run outreach campaigns using multiple methods of communication (e.g., postcards, text messages). As part of the outreach campaigns, Delta Dental of Iowa monitored the success of different modes of communication and reported that success seemed to vary based on age. Additionally, Delta Dental of Iowa used claims data to determine if it was necessary to work with Provider Relations to contract with a new provider to serve a particular area that includes members who have a high rate of missing preventive services. Of note, while Delta Dental of Iowa's interventions and evaluation methods were identified in the PIP activity as a weakness, this did not impact the performance measure validation results. [**Timeliness** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses in Delta Dental of Iowa's calculation processes during the 2021 PMV review; however, the performance measures evaluated with an associated performance rate experienced a decline over a three-year period. This decline indicates that some members were not accessing dental services to maintain or improve their oral health. [**Access**]

Why the weakness exists: The rates for *Members Who Accessed Dental Care*, *Members Who Received Preventive Dental Care*, and *Members Who Received a Preventive Examination and a Follow-Up Examination* demonstrated a decline in performance over a three-year period (from the 2019 rate). This decline was potentially impacted by the COVID-19 pandemic.

Recommendation: Although no substantial weaknesses were identified in the calculation processes, to improve performance measure rates and the prevalence of dental care, HSAG recommends that the PAHP continue to implement performance improvement strategies that could positively impact the outcomes of the performance measures.

Weakness #2: Although HSAG did not identify any substantial weaknesses in Delta Dental of Iowa's claims and provider data processing during the 2021 PMV review, DHS has noted discrepancies in Delta Dental of Iowa's paid claims in comparison to accepted encounters. [**Quality**]

Why the weakness exists: Delta Dental of Iowa confirmed it did not pay claims to non-Medicaid providers who were listed as the rendering provider on claims; however, Delta Dental of Iowa further indicated that it did not routinely validate that the billing provider was Medicaid-enrolled. DHS had indicated that its expectation was that both rendering and billing providers would need to be Medicaid-enrolled in order for DHS to accept the encounters. This issue has created a discrepancy between Delta Dental of Iowa's paid claims and accepted encounters. Although performance

measures are calculated based upon paid claims, encounter data should closely match Delta Dental of Iowa's claims; therefore, it is important to resolve any encounter data issues identified by DHS.

Recommendation: HSAG recommends that DDIA meet with DHS as needed regarding encounter validation issues and work to resolve the rejections that are being caused by the billing provider Medicaid enrollment discrepancy.

Compliance Review

Performance Results

Table 4-8 presents Delta Dental of Iowa's scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in Delta Dental of Iowa's written documents; including policies, procedures, reports, and meeting minutes; and interviews with PAHP staff members. DHS required Delta Dental of Iowa to submit a CAP for all standards scoring less than 100 percent compliant.

Table 4-8—Summary of Standard Compliance Scores for DDIA

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Disenrollment: Requirements and Limitations	6	6	6	0	0	**100%**
II	Member Rights and Member Information	18	17	14	3	1	**82%**
III	Emergency and Poststabilization Services	10	10	7	3	0	**70%**
IV	Availability of Services	7	7	7	0	0	**100%**
V	Assurances of Adequate Capacity and Services	4	4	4	0	0	**100%**
VI	Coordination and Continuity of Care	7	7	7	0	0	**100%**
VII	Coverage and Authorization of Services	10	10	9	1	0	**90%**
Total		**62**	**61**	**54**	**7**	**1**	**89%**

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

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

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

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: Delta Dental of Iowa achieved full compliance in the Disenrollment: Requirements and Limitations program area, demonstrating that the PAHP had adequate processes in place related to member and PAHP requests for disenrollment, procedures for disenrollment, and use of Delta Dental of Iowa's grievance system when receiving a disenrollment request. [**Quality**]

Strength #2: Delta Dental of Iowa achieved full compliance in the Availability of Services program area, demonstrating that the PAHP maintained and monitored a network of appropriate providers sufficient to provide adequate access to all services covered under its contract with DHS. [**Timeliness** and **Access**]

Strength #3: Delta Dental of Iowa achieved full compliance in the Assurances of Adequate Capacity and Services program area, demonstrating that the PAHP maintained the capacity to serve its enrolled members according to DHS' time/distance standards for urban and rural areas. [**Access**]

Strength #4: Delta Dental of Iowa achieved full compliance in the Coordination and Continuity of Care program area, demonstrating that the PAHP had adequate processes in place to effectively coordinate dental care for members who required care management. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Delta Dental of Iowa received a score of 70 percent in the Emergency and Poststabilization Services program area, indicating that the PAHP's lack of written processes may contribute to inappropriate provider payment denials for emergency and poststabilization services. [**Quality**]

Why the weakness exists: Delta Dental of Iowa did not have adequate processes or procedures in place that ensured payment of an emergent dental condition was not denied when a PAHP representative instructed a member to seek emergency dental services. Additionally, the PAHP did not have adequate procedures in place that ensured coverage and payment for poststabilization services.

Recommendation: In addition to developing a corrective action plan to remediate deficiencies identified within the emergency and poststabilization processes, Delta Dental of Iowa should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal regulations specific to emergency and poststabilization services.

Readiness Review

Performance Results

Table 4-9 presents the summary of results of the readiness review assessment performed by HSAG for Delta Dental of Iowa in preparation for the DWP Kids transition. The table also presents the overall completion status assigned by HSAG for each program area reviewed and the status of the remediation if one was required.

Table 4-9—Summary of Readiness Review Results for DDIA

Program Area	Overall Completion Status	Remediation Plan
Operations/Administration		
Administrative Staffing and Resources	Complete	NA
Delegation and Oversight	Complete	NA
Member and Provider Communications	Incomplete	Successfully Remediated
Grievance and Appeals	Complete	NA
Member Services and Outreach	Complete	NA
Provider Network Management	Complete	NA
Program Integrity/Compliance*	Completed by DHS	
Service Delivery		
Case Management/Care Coordination/Service Planning	Incomplete	Successfully Remediated
Quality Improvement	Complete	NA
Utilization Review	Complete	NA
Financial Management		
Financial Reporting and Monitoring*	Completed by DHS	
Financial Solvency*	Completed by DHS	
Systems Management		
Claims Management and Encounter Data*	Complete	NA

* DHS maintained responsibility for assessing the PAHP's readiness as it relates to these program areas. However, HSAG conducted a high-level review of systems management.
NA (Not Applicable) = Program area received a Complete status; therefore, a Remediation was not required.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Delta Dental of Iowa achieved a Complete status or successfully remediated all Incomplete findings for all program areas assessed by HSAG prior to program implementation, demonstrating the PAHP's capability to support its obligations to DHS under the DWP Kids contract and to ensure appropriate service delivery to the transitioning population.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for Delta Dental of Iowa.

Why the weakness exists: As no weaknesses were identified, this section is not applicable.

Recommendation: As all remediation plans were successfully implemented, this section is not applicable.

Network Adequacy Validation

Performance Results

Table 4-10 illustrates the number of active providers in the FFS network (i.e., providers with at least one FFS encounter between July 1, 2019, and December 30, 2020) who were also enrolled in a PAHP to provide services to DWP Kids members after the transition of that program from FFS to managed care.

Table 4-10—Percentage of Providers in FFS and DDIA DWP Kids Provider Networks

Provider Category	Unique FFS Network[1]	DDIA	
		Providers In-Network[2]	Percentage of FFS Network Providers in DDIA Network[3]
Endodontist	5	5	100%
General Dentist	1117	814	72.87%
Oral Surgeon	66	48	72.73%
Orthodontist	60	43	71.67%
Pedodontist	48	40	83.33%
Periodontist	4	4	100%
Prosthodontist[4]	—	—	NA

Provider Category	Unique FFS Network[1]	DDIA	
		Providers In-Network[2]	Percentage of FFS Network Providers in DDIA Network[3]
Provider Category Unknown[5]	487	20	4.11%

[1] The number of unique provider NPIs with an FFS encounter between July 1, 2019, and December 30, 2020.
[2] The number of unique provider NPIs with an FFS encounter between July 1, 2019, and December 30, 2020, that were contracted in each respective PAHP's network.
[3] The rate of providers from the FFS network who were found in each respective PAHP's network.
[4] There were no providers who submitted an FFS encounter that had a Provider Category of Prosthodontist.
[5] Providers with an FFS encounter whose provider information was not available are identified as Provider Category Unknown.

Table 4-11 shows the percentage of members residing within the time and distance specified by contract standards for general dentists and whether the contract standard was met, stratified by urbanicity (i.e., urban and rural). DHS established contract standards for the maximum allowable driving distance or driving time that members may travel to receive care from general dentists. PAHPs must ensure that 100 percent of their Medicaid members have access to dental providers within 30 miles or 30 minutes for members living in urban areas and 60 miles or 60 minutes for members living in rural areas.

Table 4-11—Percentage of Members With Access to General Dentists Within the Time and Distance Standards

PAHP	Percentage of Members With Access to General Dentists Within the Time and Distance Standards	
	Rural (60 Miles or 60 Minutes)	Urban (30 Miles or 30 Minutes)
DDIA	100.0%	100.0%

Table 4-12 displays the number of members who transitioned from FFS to managed care and are now part of DWP Kids, and the number of those members who experienced at least one disruption in their care. Approximately 85 percent of Delta Dental of Iowa members with at least one FFS encounter likely experienced a disruption in dental care.

Table 4-12—Number of Members Included in the Disruption Analysis for DDIA

PAHP	Total Number of Members[1]	Total Number of Eligible Members With an FFS Encounter	Total Number of Eligible Members With an Encounter and Disruption
DDIA	171,517	74,826	63,240

To further assess the transition from FFS to managed care, HSAG examined the change in travel time and distance from the provider who a member visited in the FFS network and the nearest available provider in the PAHP's network, if the FFS provider was not available in that PAHP's network.

Endodontists, prosthodontists, and periodontists were excluded from Table 4-13 due to the small number of providers in the sample.

Table 4-13—Number of Provider Locations by Provider Type for DDIA

PAHP	FFS Dental Provider[1]		PAHP Nearest Dental Provider		Difference Between Visited Provider and Nearest Available Providers	
	Median Time (Minutes)	Median Distance (Miles)	Median Time (Minutes)	Median Distance (Miles)	Median Time (Minutes)	Median Distance (Miles)
Urban						
General Dentist	13.00	10.60	1.30	1.00	11.70	9.60
Oral Surgeon	40.00	36.80	11.10	8.10	28.90	28.70
Orthodontist	21.00	18.50	5.80	4.50	15.20	14.00
Pedodontist	30.00	27.50	3.40	2.60	26.60	24.90
Rural						
General Dentist	32.00	28.90	3.80	3.40	28.20	25.50
Oral Surgeon	65.00	59.60	35.80	31.10	29.20	28.50
Orthodontist	51.00	46.65	29.10	26.00	21.90	20.65
Pedodontist	73.00	66.80	29.80	27.40	43.20	39.40

[1] For FFS providers, the travel time and distance are calculated from the member to the provider the member visited. This may not be the provider nearest to the member, but represents the actual time and distance traveled by the member to receive care.

HSAG assessed the acceptance of new patients as another dimension of disruption that may affect DWP Kids members. Table 4-14 shows the total number of provider locations in urban and rural areas for Delta Dental of Iowa.

Table 4-14—Number of Members Included in the Disruption Analysis for DDIA

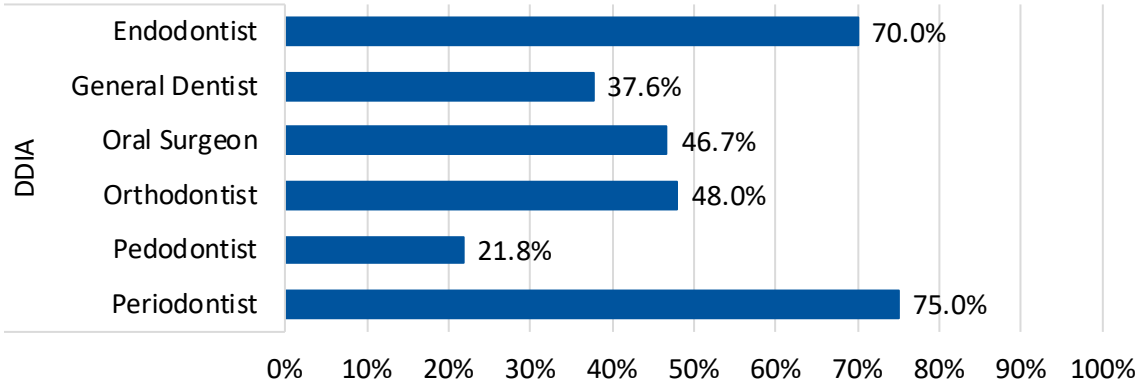
Provider Category	Number of Unique Provider Locations	
	Urban	Rural
Urban		
Endodontist	10	—
General Dentist	886	304
Oral Surgeon	158	11
Orthodontist	86	14
Pedodontist	152	4

Provider Category	Number of Unique Provider Locations	
	Urban	Rural
Periodontist	11	1
Prosthodontist	20	1

"—" indicates that the PAHP did not report any provider locations for that provider category in the urbanicity.

Figure 4-1 displays the percentage of providers who were accepting new patients for each provider category. For Delta Dental of Iowa, the percentage of providers accepting new patients ranged from 21.8 percent for pedodontists to 75.0 percent for periodontists.

Figure 4-1—Percentage of Providers who Reported Accepting New Patients for DDIA



Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV 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: Delta Dental of Iowa's provider network included considerable overlap with the FFS providers, which indicates that many of Delta Dental of Iowa's members may have been able to transition to the new PAHP network and maintain their previous providers without disruption. [**Quality** and **Access**]

Strength #2: Delta Dental of Iowa met the DHS time and distance standards for all members living in urban and rural areas. [**Access**]

Weaknesses and Recommendations

Weakness #1: The percentage of providers in the Delta Dental of Iowa network accepting new patients ranged from 21.8 percent for pedodontists to 75.0 percent for periodontists, which may be low considering the influx of new members from the DWP Kids program. [**Access**]

Why the weakness exists: This weakness may exist because the Delta Dental of Iowa provider network was already at or nearing capacity for new members prior to the addition of the DWP Kids program.

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

Encounter Data Validation

Performance Results

Encounter Data Completeness

Table 4-15 displays the results for the number of encounter records received and processed monthly.

Table 4-15—Dental Encounter Record Counts by MMIS Month for DDIA

MMIS Month	Count
August 2019	56,919
September 2019	82,510
October 2019	83,156
November 2019	110,170
December 2019	88,567
January 2020	55,773
February 2020	62,422
March 2020	118,551
April 2020	72,391
May 2020	24,065
June 2020	21,884
July 2020	77,959
August 2020	42,596
September 2020	3,600
October 2020	2,758

MMIS Month	Count
November 2020	1,784
December 2020	1,665
January 2021	1,368
February 2021	1,264
March 2021	946
Total	**910,348**

Table 4-16 displays the dental encounter volume (i.e., visit/service) and paid amount for Delta Dental of Iowa by service month.

Table 4-16—Dental Encounter Volume (i.e., Visit/Service) and Payment by Service Month for DDIA

		Volume		Payment	
Service Month	Encounter Volume	Member Count	Volume Per 1,000 MM	Paid Amount	Paid Amount PMPM
July 2019	27,933	279,160	100.1	$4,160,518	$15
August 2019	30,058	279,168	107.7	$4,641,224	$17
September 2019	26,544	279,331	95.0	$4,227,837	$15
October 2019	31,202	279,306	111.7	$4,922,142	$18
November 2019	24,785	280,453	88.4	$3,928,508	$14
December 2019	24,152	280,534	86.1	$3,861,618	$14
January 2020	26,979	280,577	96.2	$4,292,406	$15
February 2020	25,614	279,014	91.8	$4,029,437	$14
March 2020	16,546	280,258	59.0	$2,788,882	$10
April 2020	2,807	284,034	9.9	$517,618	$2
May 2020	10,503	286,970	36.6	$1,744,810	$6
June 2020	23,585	289,911	81.4	$3,703,948	$13

Encounter Data Timeliness

The first timeliness study indicator evaluates the lag between the date of service (e.g., data element detail line first date of service) and MMIS processed date. Table 4-17 displays the cumulative percentage of records processed by MMIS within specified days from the dates of service by monthly intervals.

Table 4-17—Cumulative Percentage of Dental Encounters Accepted into DHS' MMIS Since the Date Services Were Rendered for DDIA

Cumulative Percentage Results	
Submitted Within 1 Month	51.4%

Cumulative Percentage Results	
Submitted Within 2 Months	86.7%
Submitted Within 3 Months	89.8%
Submitted Within 4 Months	91.9%
Submitted Within 5 Months	93.7%
Submitted Within 6 Months	94.4%
Submitted Within 7 Months	94.8%
Submitted Within 8 Months	95.1%
Submitted Within 9 Months	95.3%
Submitted Within 10 Months	95.4%
Submitted Within 11 Months	95.6%
Submitted Within 12 Months	95.6%
Submitted Over 12 Months	0.2%
Submitted Prior to Service Date	4.2%

The second timeliness measure evaluates the lag days between the PAHP paid date and the MMIS date. This timeliness metric is used to evaluate how soon the PAHPs submit encounters to DHS after their internal processes. Table 4-18 displays the cumulative percentage of records processed by MMIS within specified days from the payment date.

Table 4-18—Cumulative Percentage of Dental Encounters Accepted into DHS' MMIS Since PAHP Payment Date for DDIA

Cumulative Percentage Results	
Submitted Within 30 Days	76.2%
Submitted Within 60 Days	93.9%
Submitted Within 90 Days	93.9%
Submitted Within 120 Days	94.3%
Submitted Within 150 Days	95.4%
Submitted Within 180 Days	95.8%
Submitted Within 210 Days	95.8%
Submitted Within 240 Days	95.8%
Submitted Within 270 Days	95.8%
Submitted Within 300 Days	95.8%
Submitted Within 330 Days	95.8%
Submitted Within 360 Days	95.8%
Submitted Over 360 Days	0.0%
Submitted Prior to Paid Date	4.2%

Field-Level Completeness and Accuracy

HSAG evaluated key data elements to determine the completeness and accuracy of DHS' dental encounter data. Table 4-19 displays the results for the key data elements in the dental encounter data.

Table 4-19—Dental Encounter Data Element Completeness and Accuracy for DDIA

Data Element	Percent Present		Percent Valid	
	Denominator	Rate	Denominator	Rate
Member ID[1]	295,806	100.0%	295,806	99.6%
Header First Date of Service[1]	295,806	100.0%	295,806	100.0%
Header Last Date of Service[1]	295,806	100.0%	295,806	100.0%
Detail First Date of Service[2]	910,348	100.0%	910,348	100.0%
Detail Last Date of Service[2]	910,348	100.0%	910,348	100.0%
Paid Date[2]	910,348	100.0%	910,348	100.0%
Billing Provider NPI[1]	295,806	100.0%	295,806	91.7%
Rendering Provider NPI[1]	295,806	100.0%	295,806	99.3%
Primary Diagnosis Code[1]	295,806	0.0%	0	NA
CDT/CPT/HCPCS Code(s)[2]	910,348	100.0%	910,348	>99.9%
Tooth Number[2]	910,348	25.5%	231,803	>99.9%
Surface Code(s)[2]	910,348	1.8%	32,029	100.0%
Oral Cavity Code(s)[2]	910,348	3.1%	27,950	100.0%

[1] Analyses were performed at the header level.
[2] Analyses were performed at the line level.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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: The distribution for the record counts by MMIS month generally conformed to a bell-shaped or trapezoid-shaped curve, which is ideal for encounter data record counts as it indicates that the PAHP's encounter data submissions were generally consistent. However, due to COVID-19, certain months deviated from the general shape; for example, where there was a large drop in record counts from March 2020 to April 2020. [**Quality** and **Timeliness**]

Strength #2: The visit/service counts by service month were relatively stable over time, with the exception of the significant drop in April 2020 due to COVID-19 service restrictions. During time periods that were not affected by service restrictions related to COVID-19, encounter data volume was relatively consistent. Similarly, the paid amount by service month also showed a similar trend to those for the visit/service counts by service month. [**Quality**]

Strength #3: Delta Dental of Iowa was timely in submitting dental encounters to DHS. [**Timeliness**]

Strength #4: Overall, the majority of Delta Dental of Iowa's key data elements were generally both complete and accurate. [**Quality**]

Weaknesses and Recommendations

Weakness #1: In assessing encounter data timeliness, there were instances in which the data submission dates were prior to the service dates and/or the encounter paid dates. [**Timeliness**]

Why the weakness exists: DHS noted that for these instances, there was a March 12, 2020, batch of encounter transactions that was generated by an internal reprocessing activity with an incorrect entry date.

Recommendation: HSAG recommends that Delta Dental of Iowa work with DHS to determine if Delta Dental of Iowa's submission dates within DHS' MMIS have been resolved and ensure that moving forward, the dates and other data elements are captured accurately.

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

To identify strengths and weaknesses and draw conclusions for Delta Dental of Iowa about the quality, timeliness, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by Delta Dental of Iowa across all EQR activities to identify common themes within Delta Dental of Iowa that impacted, or will have the likelihood to impact, member health outcomes. The overarching aggregated findings show that although Delta Dental of Iowa scored 100 percent on the Availability of Services and Assurances of Adequate Capacity and Services compliance review standards, the *Members Who Accessed Dental Care*, *Members Who Received Preventive Dental Care*, and *Members Who Received a Preventive Examination and a Follow-Up Examination* performance measure rates declined over a three-year period (from rates in 2019) for both the Medicaid and Hawki populations, suggesting barriers to accessing care that were unrelated to effective processes and procedures in place to support provider network adequacy. Additionally, although Delta Dental of Iowa continued its *Annual Dental Visits* PIP, the *Annual Dental Visits* remeasurement rates declined significantly from the baseline rate, and Delta Dental of Iowa did not meet its PIP goals. While it is likely that COVID-19 had an impact on the decreasing rates, Delta Dental of Iowa implemented interventions that were passive and did not demonstrate a positive impact on the percentage of members accessing dental services. HSAG recommends that Delta Dental of Iowa continually evaluate the success of its interventions and quickly modify its interventions or implement new interventions, as necessary, to support improvement.

Delta Dental of Iowa's provider network included considerable overlap with the FFS providers, indicating that many of Delta Dental of Iowa's members may have been able to transition to the new PAHP network and maintain their previous providers without disruption. However, the percentage of

providers in Delta Dental of Iowa's provider network accepting new patients may be low considering the influx of new members from the DWP Kids program and because Delta Dental of Iowa's provider network was already at or nearing capacity for new members prior to the addition of the DWP Kids program. This may present barriers to accessing dental services and further impact the rates for the *Members Who Accessed Dental Care*, *Members Who Received Preventive Dental Care*, and *Members Who Received a Preventive Examination and a Follow-Up Examination* performance measures.

Of note, due to the COVID-19 pandemic during CY 2021, many preventive services were negatively affected across the country as states followed orders to reduce the use of nonemergent services, including dental services, in order to slow the spread of coronavirus disease. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have impacted performance outcomes in CY 2021.

Managed Care of North America Dental

Performance Improvement Projects

Performance Results

Table 4-20 displays the overall validation status, the baseline and remeasurement results, and the PAHP-designated goal for the PIP topic.

Table 4-20—Overall Validation Rating for MCNA

PIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Increase the Percentage of Dental Services	*Not Met*	The percentage of members 19 years of age and older who had at least one dental visit during the measurement year.	24.4%	24.6% ⇔	19.7% ↓	28.4%

R1 = Remeasurement 1
R2 = Remeasurement 2 (to be included in CY 2021 annual assessment)
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

Table 4-21 displays the interventions implemented to address the barriers identified by Managed Care of North America Dental using QI and causal/barrier analysis processes.

Table 4-21—Remeasurement 2 Interventions for MCNA

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation 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: Managed Care of North America Dental designed a methodologically sound PIP. [**Quality**]

Strength #2: Managed Care of North America Dental used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Managed Care of North America Dental demonstrated a significant decrease in the percentage of members with a dental visit during the second remeasurement period. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Managed Care of North America Dental indicated that the COVID-19 pandemic resulted in provider office closures due to State-mandated use of emergency and/or urgent

care for a portion of the measurement period. However, it appears that Managed Care of North America Dental continued the same interventions as those implemented prior to the pandemic.

Recommendation: HSAG recommends that Managed Care of North America Dental revisit its causal/barrier analysis process and include challenges associated with the pandemic. Additional interventions, or modifications to the existing interventions, may be needed to mitigate the barriers associated with the pandemic.

Performance Measure Validation

Performance Results

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

Table 4-22 displays measure designation and reportable measure rates. Managed Care of North America Dental received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 4-22—Performance Measure Designation and Rates for MCNA

	Performance Measure	2019 Rate	2020 Rate	2021 Measure Designation	2021 Results		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	101,580	116,131	*R*	138,535	—	—
2	*Members Who Accessed Dental Care*	22.14%	19.76%	*R*	138,535	25,731	18.57%
3	*Members Who Received Preventive Dental Care*	67.84%	63.13%	*R*	25,731	16,754	65.11%
4	*Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation*	10,400	9,860	*R*	12,499	—	—

	Performance Measure	2019 Rate	2020 Rate	2021 Measure Designation	2021 Results		
					Denominator	Numerator	Rate
5	*Members Who Received an Oral Evaluation During the Measurement Year, Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation, and Received an Oral Evaluation 6–12 Months Prior to the Oral Evaluation*	4,095	4,165	*R*	—	4,288	—
6	*Members Who Received a Preventive Examination and a Follow-Up Examination*	39.38%	42.24%	*R*	12,499	4,288	34.31%

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Managed Care of North America Dental implemented a Practice Site Performance Summary Report in April 2020 that was distributed to all DWP providers to give quarterly updates on several operational and clinical performance trends. Preventive and treatment service rates for adults were tracked quarterly within the Practice Site reports, allowing providers to see their performance trend quarter-over-quarter, along with a comparison to peer rates for preventive and treatment services for the current quarter. The implementation of this report helped MCNA to efficiently target individual practice performance and facilitate meaningful provider engagement in patient education and outreach while encouraging providers to take more responsibility for the rates of preventive services within their practices. This intervention should also support both timeliness of care and access to care based on its potential to give providers information to identify missed preventive services. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses in Managed Care of North America Dental's calculation processes during the 2021 PMV review; however, the performance measures evaluated with an associated performance rate experienced a decline over a three-year

period. This performance indicates that some members were not accessing dental services at adequate rates to maintain or improve their oral health. [**Access**]

Why the weakness exists: The rates for *Members Who Accessed Dental Care*, and *Members Who Received a Preventive Examination and a Follow-Up Examination* demonstrated a decline in performance over a three-year period. Additionally, while the *Members Who Received Preventive Dental Care* rate improved slightly from the CY 2020 rate, it remained below the CY 2019 rate. The overall decline in performance was potentially impacted by the COVID-19 pandemic.

Recommendation: Although no substantial weaknesses were identified in the calculation processes, to improve performance measure rates and the prevalence of dental care, HSAG recommends that the PAHP continue to implement performance improvement strategies that could positively impact the outcomes of the performance measures.

Weakness #2: Although HSAG did not identify any substantial weaknesses in Managed Care of North America Dental's claims and provider data processing during the 2021 PMV review, DHS has noted discrepancies in Managed Care of North America Dental's paid claims in comparison to accepted encounters. [**Quality**]

Why the weakness exists: Managed Care of North America Dental paid claims for a large Federally Quality Health Center that was not enrolled in Medicaid. DHS had indicated that its expectation was that billing providers would need to be Medicaid-enrolled in order for DHS to accept the encounters. This issue has created a discrepancy between Managed Care of North America Dental's paid claims and accepted encounters. Although performance measures are calculated based upon paid claims, encounter data should closely match Managed Care of North America Dental's claims; therefore, it is important to resolve any encounter data issues identified by DHS.

Recommendation: HSAG recommends that Managed Care of North America Dental continue to work with DHS regarding encounter validation issues and work to resolve the rejections that are being caused by the billing provider Medicaid enrollment discrepancy.

Compliance Review

Performance Results

Table 4-23 presents Managed Care of North America Dental's scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in Managed Care of North America Dental's written documents; including policies, procedures, reports, and meeting minutes; and interviews with PAHP staff members. DHS required Managed Care of North America to submit a CAP for all standards scoring less than 100 percent compliant.

Table 4-23—Summary of Standard Compliance Scores for MCNA

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Disenrollment: Requirements and Limitations	6	6	6	0	0	**100%**
II	Member Rights and Member Information	18	17	15	2	1	**88%**
III	Emergency and Poststabilization Services	10	10	10	0	0	**100%**
IV	Availability of Services	7	7	7	0	0	**100%**
V	Assurances of Adequate Capacity and Services	4	4	4	0	0	**100%**
VI	Coordination and Continuity of Care	7	7	6	1	0	**86%**
VII	Coverage and Authorization of Services	10	10	10	0	0	**100%**
Total		**62**	**61**	**58**	**3**	**1**	**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.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review 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: Managed Care of North America Dental achieved full compliance in the Disenrollment: Requirements and Limitations program area, demonstrating that the PAHP had adequate processes in place related to member and PAHP requests for disenrollment, procedures for disenrollment, and use of Managed Care of North America Dental's grievance system when receiving a disenrollment request. [**Quality**]

Strength #2: Managed Care of North America Dental achieved full compliance in Emergency and Poststabilization Services program area, demonstrating that the PAHP had sufficient processes in place to ensure members' access to, the coverage of, and payment for emergency and poststabilization care services. [**Access**]

Strength #3: Managed Care of North America Dental achieved full compliance in the Availability of Services program area, demonstrating that the PAHP maintained and monitored a network of appropriate providers that was sufficient to provide adequate access to all services covered under its contract with DHS. [**Timeliness** and **Access**]

Strength #4: Managed Care of North America Dental achieved full compliance in the Assurances of Adequate Capacity and Services program area, demonstrating that the PAHP maintained the capacity to serve its enrolled members according to DHS' time/distance standards for urban and rural areas. [**Access**]

Strength #5: Managed Care of North America Dental achieved full compliance in the Coverage and Authorization of Services program area, demonstrating that the PAHP maintained adequate processes that ensured members receive timely and adequate notice of prior authorization decisions, including decisions that result in an ABD to the member. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Managed Care of North America Dental achieved scores of 86 percent or above in all program areas reviewed, indicating that no significant weaknesses were identified, and the PAHP had appropriate processes, procedures, and plans in place to promote members' access to timely and quality care. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: No significant weaknesses were identified; therefore, this section is not applicable.

Recommendation: Although no significant weaknesses were identified, Managed Care of North America Dental should continually evaluate its processes, procedures, and monitoring efforts to ensure that it maintains compliance with all federal and State obligations.

Readiness Review

Performance Results

Table 4-24 presents the summary of results of the readiness review assessment performed by HSAG for Managed Care of North America Dental in preparation for the DWP Kids transition. The table presents the overall completion status assigned by HSAG for each program area reviewed and the status of the remediation if one was required.

Table 4-24—Summary of Readiness Review Results for MCNA

Program Area	Overall Completion Status	Remediation Plan
Operations/Administration		
Administrative Staffing and Resources	Incomplete	Successfully Remediated
Delegation and Oversight	Complete	NA

Program Area	Overall Completion Status	Remediation Plan
Member and Provider Communications	Incomplete	Successfully Remediated
Grievance and Appeals	Complete	NA
Member Services and Outreach	Complete	NA
Provider Network Management	Complete	NA
Program Integrity/Compliance*	Completed by DHS	
Service Delivery		
Case Management/Care Coordination/Service Planning	Incomplete	Successfully Remediated
Quality Improvement	Complete	NA
Utilization Review	Incomplete	Successfully Remediated
Financial Management		
Financial Reporting and Monitoring*	Completed by DHS	
Financial Solvency*	Completed by DHS	
Systems Management		
Claims Management and Encounter Data*	Complete	NA

* DHS maintained responsibility for assessing the PAHP's readiness as it relates to these program areas. However, HSAG conducted a high-level review of systems management.

NA (Not Applicable) = Program area received a Complete status; therefore, a Remediation was not required.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Managed Care of North America Dental achieved a Complete status or successfully remediated all Incomplete findings for all program areas assessed by HSAG, demonstrating the PAHP's capability to support its obligations to DHS under the DWP Kids contract and to ensure appropriate service delivery to the transitioning population.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for Managed Care of North America Dental.

Why the weakness exists: As no weaknesses were identified, this section is not applicable.

Recommendation: As no weaknesses were identified, this section is not applicable.

Network Adequacy Validation

Performance Results

Table 4-25 illustrates the number of active providers in the FFS network (i.e., providers with at least one FFS encounter between July 1, 2019, and December 30, 2020) who were also enrolled in a PAHP to provide services to DWP Kids members after the transition of that program from FFS to managed care.

Table 4-25—Percentage of Providers in FFS and MCNA DWP Kids Provider Networks

Provider Category	Unique FFS Network[1]	MCNA	
		Providers In-Network[2]	Percentage of FFS Network Providers in DDIA Network[3]
Endodontist	5	4	80%
General Dentist	1117	326	29.19%
Oral Surgeon	66	22	33.33%
Orthodontist	60	13	21.67%
Pedodontist	48	21	43.75%
Periodontist	4	2	50%
Prosthodontist[4]	—	—	NA
Provider Category Unknown[5]	487	16	3.29%

[1] The number of unique provider NPIs with an FFS encounter between July 1, 2019,and December 30, 2020.
[2] The number of unique provider NPIs with an FFS encounter between July 1, 2019, and December 30, 2020, that were contracted in each respective PAHP's network.
[3] The rate of providers from the FFS network who were found in each respective PAHP's network.
[4] There were no providers who submitted an FFS encounter that had a Provider Category of Prosthodontist.
[5] Providers with an FFS encounter whose provider information was not available are identified as Provider Category Unknown.

Table 4-26 shows the percentage of members residing within the time and distance specified by contract standards for general dentists and whether the contract standard was met, stratified by urbanicity (i.e., urban and rural). DHS established contract standards for the maximum allowable driving distance or driving time that members may travel to receive care from general dentists. PAHPs must ensure that 100 percent of their Medicaid members have access to dental providers within 30 miles or 30 minutes for members living in urban areas and 60 miles or 60 minutes for members living in rural areas.

Table 4-26—Percentage of Members With Access to General Dentists Within the Time and Distance Standards

PAHP	Percentage of Members With Access to General Dentists Within the Time Distance Standards	
	Rural (60 Miles or 60 Minutes)	Urban (30 Miles or 30 Minutes)
MCNA	100.0%	98.37%

Table 4-27 displays the number of members who transitioned from FFS to managed care and are now part of DWP Kids, and the number of those members who experienced at least one disruption in their care. Approximately 85 percent of MCNA members with at least one FFS encounter likely experienced a disruption in dental care.

Table 4-27—Number of Members Included in the Disruption Analysis for MCNA

PAHP	Total Number of Members[1]	Total Number of Eligible Members With an FFS Encounter	Total Number of Eligible Members With an Encounter and Disruption
MCNA	126,651	48,591	41,317

To further assess the transition from FFS to managed care, HSAG examined the change in travel time and distance from the provider who a member visited in the FFS network and the nearest available provider in the PAHP's network, if the FFS provider was not available in that PAHP network. Endodontists, prosthodontists, and periodontists were excluded from Table 4-28 due to the small number of providers in the sample.

Table 4-28—Number of Provider Locations by Provider Type for MCNA

PAHP	FFS Dental Provider[1]		PAHP Nearest Dental Provider		Difference Between Visited Provider and Nearest Available Providers	
	Median Time (Minutes)	Median Distance (Miles)	Median Time (Minutes)	Median Distance (Miles)	Median Time (Minutes)	Median Distance (Miles)
Urban						
General Dentist	13.00	10.40	2.20	1.70	10.80	8.70
Oral Surgeon	36.00	32.05	23.95	18.50	12.05	13.55
Orthodontist	21.00	18.80	19.60	13.90	1.40	4.90
Pedodontist	20.50	17.95	4.80	3.70	15.70	14.25
Rural						
General Dentist	35.00	32.15	18.75	17.10	16.25	15.05
Oral Surgeon	67.00	61.40	57.05	47.45	9.95	13.95
Orthodontist	61.00	56.20	44.35	40.20	16.65	16.00
Pedodontist	71.00	65.20	59.30	54.25	11.70	10.95

[1] For FFS providers, the travel time and distance are calculated from the member to the provider the member visited. This may not be the provider nearest to the member, but represents the actual time and distance traveled by the member to receive care.

HSAG assessed the acceptance of new patients as another dimension of disruption that may affect DWP Kids members. Table 4-29 shows the total number of provider locations in urban and rural areas for Managed Care of North America.

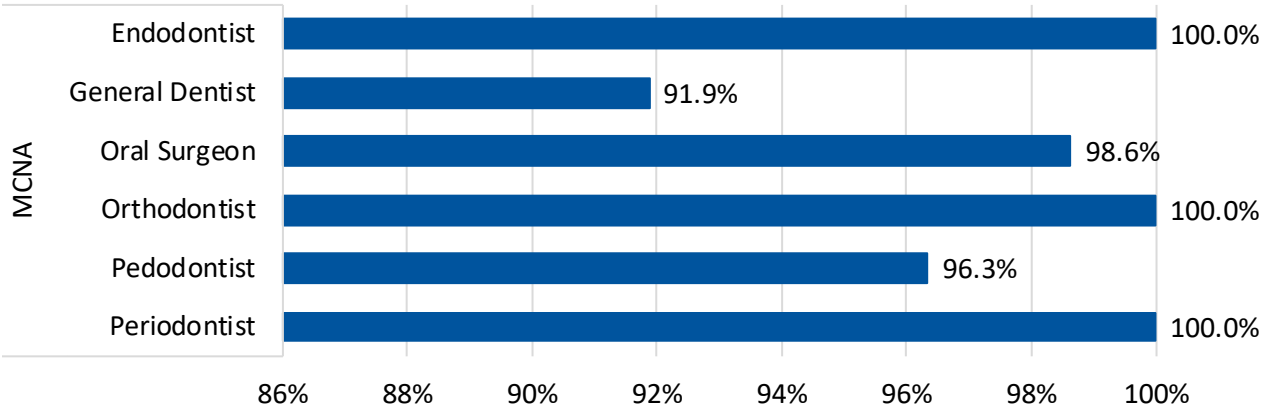
Table 4-29—Number of Members Included in the Disruption Analysis for MCNA

Provider Category	Number of Unique Provider Locations	
	Urban	Rural
Urban		
Endodontist	11	—
General Dentist	729	70
Oral Surgeon	69	4
Orthodontist	26	2
Pedodontist	82	—
Periodontist	12	—
Prosthodontist	21	—

"—" indicates that the PAHP did not report any provider locations for that provider category in the urbanicity.

Figure 4-2 displays the percentage of providers who were accepting new patients for each provider category.

Figure 4-2—Percentage of Providers who Reported Accepting New Patients for MCNA



Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV 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: In the Managed Care of North America provider network, over 90 percent of providers for all provider categories were accepting new patients, which indicates that the network may have capacity for members who experienced a disruption in care to find a new provider. [**Quality** and **Access**]

Strength #2: All members in urban areas had access to general dental providers within the time and distance standards. [**Access**]

Weaknesses and Recommendations

Weakness #1: Managed Care of North America's provider network had a limited amount of overlap with the FFS provider network, which indicates that members may have needed to find new providers in the PAHP network and may have experienced a disruption. [**Quality** and **Access**]

Why the weakness exists: The weakness may exist due to a lack of overlap between the FFS provider network and Managed Care of North America's provider network at the start of the DWP Kids transition.

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

Encounter Data Validation

Performance Results

Encounter Data Completeness

Table 4-30 displays the results for the number of encounter records received and processed monthly.

Table 4-30—Dental Encounter Record Counts by MMIS Month for MCNA

MMIS Month	Count
July 2019	1,168
August 2019	14,090
September 2019	15,879
October 2019	22,340
November 2019	18,687
December 2019	17,974
January 2020	14,208

MMIS Month	Count
February 2020	23,527
March 2020	21,816
April 2020	12,714
May 2020	6,429
June 2020	10,414
July 2020	11,033
August 2020	554
September 2020	474
October 2020	422
November 2020	258
December 2020	184
January 2021	194
February 2021	512
March 2021	1,071
April 2021	4
Total	**193,952**

Table 4-31 displays the dental encounter volume (i.e., visit/service) and paid amount for MCNA by service month.

Table 4-31—Dental Encounter Volume (i.e., Visit/Service) and Payment by Service Month for MCNA

		Volume		Payment	
Service Month	Encounter Volume	Member Count	Volume Per 1,000 MM	Paid Amount	Paid Amount PMPM
July 2019	5,382	112,333	47.9	$975,630	$9
August 2019	5,752	113,251	50.8	$1,029,311	$9
September 2019	5,637	113,269	49.8	$991,710	$9
October 2019	6,600	113,648	58.1	$1,176,380	$10
November 2019	5,467	114,301	47.8	$1,011,746	$9
December 2019	5,264	115,418	45.6	$965,575	$8
January 2020	6,011	115,810	51.9	$1,096,824	$9
February 2020	5,599	116,009	48.3	$1,007,813	$9
March 2020	4,062	116,347	34.9	$789,275	$7
April 2020	1,350	118,808	11.4	$266,599	$2
May 2020	2,384	121,381	19.6	$406,521	$3
June 2020	4,425	123,705	35.8	$854,098	$7

Encounter Data Timeliness

The first timeliness study indicator evaluates the lag between the date of service (e.g., data element detail line first date of service) and MMIS processed date. Table 4-32 displays the cumulative percentage of records processed by MMIS within specified days from the dates of service by monthly intervals.

Table 4-32—Cumulative Percentage of Dental Encounters Accepted into DHS' MMIS Since the Date Services Were Rendered for MCNA

Cumulative Percentage Results	
Submitted Within 1 Month	81.1%
Submitted Within 2 Months	93.6%
Submitted Within 3 Months	95.7%
Submitted Within 4 Months	97.1%
Submitted Within 5 Months	97.8%
Submitted Within 6 Months	98.2%
Submitted Within 7 Months	98.6%
Submitted Within 8 Months	98.9%
Submitted Within 9 Months	99.2%
Submitted Within 10 Months	99.5%
Submitted Within 11 Months	99.7%
Submitted Within 12 Months	99.8%
Submitted Over 12 Months	0.2%
Submitted Prior to Service Date	0.0%

The second timeliness measure evaluates the lag days between the PAHP paid date and the MMIS date. This timeliness metric is used to evaluate how soon the PAHPs submit encounters to DHS after their internal processes. Table 4-33 displays the cumulative percentage of records processed by MMIS within specified days from the payment date.

Table 4-33—Cumulative Percentage of Dental Encounters Accepted into DHS' MMIS Since PAHP Payment Date for MCNA

Cumulative Percentage Results	
Submitted Within 30 Days	98.9%
Submitted Within 60 Days	99.3%
Submitted Within 90 Days	99.4%
Submitted Within 120 Days	99.4%
Submitted Within 150 Days	99.5%
Submitted Within 180 Days	99.5%
Submitted Within 210 Days	99.5%
Submitted Within 240 Days	99.5%
Submitted Within 270 Days	99.6%

Cumulative Percentage Results	
Submitted Within 300 Days	99.9%
Submitted Within 330 Days	100.0%
Submitted Within 360 Days	100.0%
Submitted Over 360 Days	0.0%
Submitted Prior to Paid Date	0.0%

Field-Level Completeness and Accuracy

HSAG evaluated key data elements to determine the completeness and accuracy of DHS' dental encounter data. Table 4-34 displays the results for the key data elements in the dental encounter data.

Table 4-34—Dental Encounter Data Element Completeness and Accuracy for MCNA

Data Element	Percent Present		Percent Valid	
	Denominator	Rate	Denominator	Rate
Member ID[1]	57,956	100.0%	57,956	99.9%
Header First Date of Service[1]	57,956	100.0%	57,956	100.0%
Header Last Date of Service[1]	57,956	100.0%	57,956	100.0%
Detail First Date of Service[2]	193,952	100.0%	193,952	100.0%
Detail Last Date of Service[2]	193,952	100.0%	193,952	100.0%
Paid Date[2]	193,952	100.0%	193,952	100.0%
Billing Provider NPI[1]	57,956	100.0%	57,956	95.0%
Rendering Provider NPI[1]	57,956	100.0%	57,956	>99.9%
Primary Diagnosis Code[1]	57,956	14.0%	8,101	100.0%
CDT/CPT/HCPCS Code(s)[2]	193,952	100.0%	193,952	>99.9%
Tooth Number[2]	193,952	34.7%	67,301	100.0%
Surface Code(s)[2]	193,952	11.4%	46,975	100.0%
Oral Cavity Code(s)[2]	193,952	3.0%	5,745	100.0%

[1] Analyses were performed at the header level.
[2] Analyses were performed at the line level.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV 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: The distribution for the record counts by MMIS month generally conformed to a bell-shaped or trapezoid-shaped curve, which is ideal for encounter data record counts as it indicates that the PAHP's encounter data submissions were generally consistent. However, due to COVID-19, certain months deviated from the general shape; for example, where there was a large drop in record counts from March 2020 to April 2020. [**Quality** and **Timeliness**]

Strength #2: The visit/service counts by service month were relatively stable over time, with the exception of the significant drop in April 2020 due to COVID-19 service restrictions. During time periods that were not affected by service restrictions related to COVID-19, encounter data volume was relatively consistent. Similarly, the paid amount by service month also showed a similar trend to those for the visit/service counts by service month. [**Quality**]

Strength #3: Managed Care of North America Dental was timely in submitting dental encounters to DHS. [**Timeliness**]

Strength #4: Overall, the majority of Managed Care of North America Dental's key data elements were generally both complete and accurate. [**Quality**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses from the administrative profile analysis of the EDV study.

Why the weakness exists: No significant weaknesses were identified; therefore, this section is not applicable.

Recommendation: While no substantial weaknesses were identified, HSAG recommends that Managed Care of North America Dental continually monitor its encounter submissions to DHS to ensure complete, accurate, and timely encounter data submissions.

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

To identify strengths and weaknesses and draw conclusions for Managed Care of North America Dental about the quality, timeliness, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by Managed Care of North America Dental across all EQR activities to identify common themes within Managed Care of North America Dental that impacted, or will have the likelihood to impact, member health outcomes. The overarching aggregated findings showed that although Managed Care of North America Dental scored 100 percent on the Availability of Services and Assurances of Adequate Capacity and Services compliance review standards, the *Members Who Accessed Dental Care*, *Members Who Received Preventive Dental Care*, and *Members Who Received a Preventive Examination and a Follow-Up Examination* performance measure rates declined from the CY 2019 rates, suggesting barriers to accessing care that were unrelated to effective processes and procedures in place to support provider network adequacy. Additionally, although Managed Care of North America Dental continued its *Increase the Percentage of Dental*

Services PIP, the remeasurement rate declined significantly from the baseline rate, and Managed Care of North America Dental did not meet its PIP goals. While it is likely that COVID-19 had an impact on the decreasing rates, the PIP interventions did not appear to demonstrate a positive impact on the percentage of members accessing dental services. HSAG recommends that Managed Care of North America Dental continually evaluate the success of its interventions and quickly modify its interventions or implement new interventions, as necessary, to support improvement.

While Managed Care of North America's provider network had over 90 percent of providers for all provider categories accepting new patients, Managed Care of North America's provider network had a limited amount of overlap with the FFS provider network, which indicates that members may have needed to find new providers in the PAHP network and may have experienced a disruption due to a lack of overlap between the FFS provider network and Managed Care of North America's provider network at the start of the DWP Kids transition. Managed Care of North America should closely monitor its provider network and promptly mitigate any identified barriers for members in accessing dental services.

Of note, due to the COVID-19 pandemic during CY 2021, many preventive services were negatively affected across the country as states followed orders to reduce the use of nonemergent services, including dental services, in order to slow the spread of coronavirus disease. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have impacted performance outcomes in CY 2021.

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the CY 2021 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Iowa Medicaid program. The recommendations provided to each MCO for the EQR activities in the *Calendar Year 2020 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—AGP

1. Recommendation—Performance Improvement Projects
HSAG recommended the following: • Although the *Member Satisfaction* PIP has concluded, Amerigroup Iowa should revisit its causal/barrier analysis to determine whether barriers identified continue to be barriers and determine if any new barriers exist that require the development of new, innovative interventions.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Amerigroup Iowa has revisited its causal/barrier analysis and determined that the barriers listed in the PIP persist, but the current interventions are adequately addressing those barriers. Regarding the member's perception of customer service reps, we are continuing to closely monitor the "Voice of the Customer" (post call member survey) and bring those results to our quarterly Service Quality Committee to analyze the results. Ongoing efforts by the National Call Center to coach the reps [representatives] who are not meeting standards has resulted in an increase in overall satisfaction over time. Regarding incorrect or conflicting plan specific information stored in the knowledge library for call center associates, all documents have been updated; however, as information is ever changing this review process must remain in place to ensure ongoing accuracy of these documents so that the call center associates are able to provide accurate information and quickly assist the member. No new barriers have been identified.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Our CAHPS results have shown improvement from the 2020 survey to the 2021 survey. For Rating of the Health Plan, the result was 59.13% in 2020 to 65.36% for the 2021 Survey.
c. Identify any barriers to implementing initiatives: • COVID-19 presented in March 2020 and continues to persist.
HSAG Assessment: HSAG determined that Amerigroup Iowa addressed the prior recommendations.

2. Recommendation—Validation of Performance Measures

HSAG recommended the following:

PMV results:

- 2019—Amerigroup Iowa should revise its processes to allow automated reporting of data from its software, with quality assurance steps in place, eliminating the need for manual abstraction of performance measure data.
- 2020—While the performance measure specifications were updated to allow for hybrid reporting of all measures, Amerigroup Iowa should revise its processes to allow automated reporting of data from its software, with quality assurance steps in place, eliminating the need for manual abstraction of performance measure data. This would reduce administrative burden on Amerigroup Iowa while still providing a complete picture of the MCO's performance as it relates to care management of members receiving HCBS.

HEDIS results:

- Amerigroup Iowa should conduct a root cause analysis or focused study to determine why women 16 to 24 years of age identified as sexually active were not getting screened for chlamydia to reduce the potential for serious and irreversible complications such as pelvic inflammatory disease and infertility. In addition, Amerigroup Iowa should conduct a root cause analysis or focused study to determine why women were not receiving timely postpartum care in order to help members access effective contraception and manage chronic health conditions, which left untreated can increase the risk of short interval pregnancies and preterm birth rates. Upon identification of a root cause, Amerigroup Iowa should implement appropriate interventions to improve low performance rates within the Women's Health domain.
- Amerigroup Iowa should conduct a root cause analysis or focused study to determine why its patients with cardiovascular disease who need statin therapy were not receiving medications to help lower their cholesterol and the risk of heart disease and stroke. Upon identification of a root cause, Amerigroup Iowa should implement appropriate interventions to improve the performance rate of the measure.
- Amerigroup Iowa should conduct a root cause analysis or focused study to determine why its patients with severe mental illnesses and diabetes were not receiving monitoring or screening. Members with these conditions are two to three times more likely to suffer from premature death than the general population. The leading cause for this shortened life expectancy is cardiovascular disease, which can be related to ongoing member utilization of antipsychotic medications combined with general unhealthy lifestyles (e.g., lack of physical activity, lack of appropriate nutrition, etc.). Upon identification of a root cause, Amerigroup Iowa should implement appropriate interventions to improve the performance rates of these measures.
- Amerigroup Iowa should conduct a root cause analysis or focused study to identify barriers to medication management in order to minimize antibiotic exposure and preventive antibiotic resistance, which could reduce the spread of antibiotic-resistant bacterial infections, and to ensure that members have timely access to appropriate medications after a hospitalization or ED visit related to COPD. Upon identification of a root cause, Amerigroup Iowa should implement appropriate interventions to improve the performance rates for these measures.

2. Recommendation—Validation of Performance Measures
MCP's Response—PMV (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • While we are not currently moving towards automation, we have standardized the manual review process, and include training and quality assurance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The manual review needed for certain measures includes quality assurance reviews. Overall, our performance measures for PMV have improved year after year.
c. Identify any barriers to implementing initiatives: • Care Plans for Habilitation and Children's' Mental Health Waivers are housed externally with the Integrated Health Homes, and not in our internal system. • In demonstrating PMV measures, we have understood that narrative evidence is preferred, which would be difficult to extract from an automated system. Even if we had an automated system, we would need to complete a manual review of care plans to ensure accuracy.
MCP's Response—HEDIS Results: Chlamydia Screening (CHL) (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Amerigroup Iowa Quality department contacted Polk County Public Health department to discuss STD [sexually transmitted disease] screening and their claims process, to explore claims data and/or supplemental data exchange to improve the Chlamydia HEDIS rate. • Amerigroup Iowa initiated provider education to improve the HEDIS rate such as a monthly provider resource email, measure education, member resources and incentives, Gap in Care reports and supplemental EMR [electronic medical record] data exchange. • Amerigroup continues to monitor denominator and numerator fluctuations through monthly HEDIS rates and monthly benchmark reports. A root cause analysis was initiated and reviewed with the HEDIS Task Force workgroup consisting of interdepartmental associates.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Amerigroup Iowa's eligible population has more than doubled Year Over Year (YOY) from 2017 to 2020, resulting in limited improvement over the rate, resulting in our FINAL HEDIS CHL rate to show a decline, but remains stable at the NCQA 10th percentile. – HEDIS 2019 MY 2018 – 47.44 (10th percentile) – HEDIS 2020 MY 2019 – 48.50 (10th percentile) – HEDIS 2021 MY 2020 – 44.86 (10th percentile)
c. Identify any barriers to implementing initiatives: • Amerigroup continues to see a significant percentage of members who fall into this population consistently seek screening services at Department of Public Health for this screening. The Department of Public Health does not submit claims to the MCO, which results in missing claims data to capture numerator compliance. • COVID-19 Pandemic in 2020 affected rates and continues to impact member compliance.

2. Recommendation—Validation of Performance Measures
MCP's Response—HEDIS Results: Postpartum Care (PPC) (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Amerigroup initiated Provider CPT [current procedural termination] Category II coding education specific to Prenatal and Postpartum Care. • Amerigroup Iowa initiated provider education to improve the HEDIS rate such as a monthly Provider resource email, measure education, member resources and incentives, Gap in Care reports and supplemental EMR data exchange. • Amerigroup continues to monitor denominator and numerator fluctuations through monthly HEDIS rates and monthly benchmark reports. A root cause analysis was initiated and reviewed with the HEDIS Task Force workgroup consisting of interdepartmental associates. • Amerigroup provides telephonic member outreach to provide education on the importance of postpartum care and assist members with scheduling their postpartum visits.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HEDIS 2020 MY2019: Postpartum Care – 62.63 (33rd percentile) • HEDIS 2021 MY2020: Postpartum Care – 45.18 (5th percentile)
c. Identify any barriers to implementing initiatives: • Global Billing for prenatal and postpartum billing resulting in limited claims data affecting numerator compliance. • COVID-19 Pandemic in 2020 affected rates and continues to impact member compliance.
MCP's Response—HEDIS Results: Statin Therapy for Patients with Cardiovascular Disease (SPD) (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Amerigroup's Quality team and External Pharmacy Vendor have established monthly and/or quarterly meetings with pharmacy team members to review pharmacy department outreach to providers and members around the measure and other pharmacy measures. • Provider notification for eligible members' adherence with medication. • Member outreach to eligible members for refill reminders. • Amerigroup Iowa initiated provider education to improve the HEDIS rate such as a measure education, Gap in Care reports and supplemental EMR data exchange. • Amerigroup continues to monitor denominator and numerator fluctuations through monthly HEDIS rates and monthly benchmark reports. A root cause analysis was initiated and reviewed with the HEDIS Task Force workgroup consisting of interdepartmental associates.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HEDIS MY2020 MY2019 – Received Statin Therapy – 72.07 (10th percentile) – Statin Adherence – 68.66 (66th percentile) • HEDIS 2021 MY2020 – Received Statin Therapy – 81.21 (50th percentile)

2. Recommendation—Validation of Performance Measures
– Statin Adherence – 72.84 (66th percentile)
c. Identify any barriers to implementing initiatives: • None identified at this time.
MCP's Response—HEDIS Results: Mental Illnesses and Diabetes – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The Diabetes Screening for Schizophrenia or Bipolar Disorder Using Antipsychotic Meds (SSD-AD) measure was added to the Health Home Quality Incentive Program (HHQIP) for the 2021 performance measurement period. • Amerigroup Iowa initiated provider education to improve the HEDIS rate such as a monthly Provider resource educational email, member resources, Gap in Care reports and supplemental EMR data exchange. • Amerigroup continues to monitor denominator and numerator fluctuations through monthly HEDIS rates and monthly benchmark reports. A root cause analysis was initiated and reviewed with the Behavioral Health HEDIS Task Force workgroup consisting of Interdepartmental associates.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HEDIS MY2020 MY 2019 – 77.62 (10th percentile) • HEDIS 2021 MY 2020 – 74.63 (5th percentile)
c. Identify any barriers to implementing initiatives: • COVID-19 pandemic in 2020 limiting member's access to care in a timely manner. • Amerigroup Iowa's eligible population also increased which then resulted in a decrease in numerator compliance.
MCP's Response—HEDIS Results: Emergency Department (ED) and Pharmacotherapy Management of COPD Exacerbation (PCE) (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Amerigroup has initiated cross interdepartmental internal ED Utilization workgroup to discuss member utilization, diagnosis post ED visit and potential barriers to timely access to medications after ED visit. • Amerigroup will be initiating a member outreach program, via SMS (texting) campaigns targeting members utilizing ED. • Amerigroup's Quality team and External Pharmacy vendor have established monthly and/or quarterly meetings with pharmacy team members to review pharmacy department outreach to providers and members around the measure and other pharmacy measures. • Amerigroup Iowa initiated provider education to improve the HEDIS rate such as a monthly Provider resource email, measure education, member resources, Gap in Care reports and supplemental EMR data exchange.

2. Recommendation—Validation of Performance Measures
• Provider notification for eligible members' adherence with medication. • Member outreach to eligible members for refill reminders.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Pharmacotherapy Management of COPD Exacerbation (PCE) rates: • HEDIS 2019 MY2018: – Systemic Corticosteroid – 38.96 (less than 5th percentile) – Bronchodilator – 45.54 (less than 5th percentile) • HEDIS 2020 MY2019: – Systemic Corticosteroid – 59.27 (10th percentile) – Bronchodilator – 69.47 (10th percentile) • HEDIS 2021 MY2020: – Systemic Corticosteroid – 74.41 (50th percentile) – Bronchodilator – 83.39 (33rd percentile)
c. Identify any barriers to implementing initiatives: • Depending on hospital pharmacy hours some members are being discharged without medications.
HSAG Assessment: HSAG determined that Amerigroup Iowa addressed the prior recommendations; however, the MCO demonstrates ongoing opportunities for improvement. HSAG recommends that Amerigroup Iowa continue to focus on improvement strategies for those measures that declined in performance from the prior MY.

3. Recommendation—Compliance Review
HSAG recommended the following: • As Amerigroup Iowa was required to submit a CAP to remediate the deficiencies, Amerigroup Iowa should proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented, Amerigroup Iowa should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies. • Amerigroup Iowa should review program requirements [Member Information and Member Rights] with all appropriate staff members responsible for functions pertaining to member services, including member information, to ensure that they have an appropriate understanding of the expectations under each requirement.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • CAPs required by external audits are monitored by Anthem Corporate Compliance on a quarterly basis. • All associates supporting Amerigroup Iowa are required to complete an annual Cultural Competency course that includes Member Rights requirements. Associates participating in community events are required to complete an additional Marketing Integrity course that educates on Member Information and Member Rights requirements.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • EQR Compliance Review scores have improved from Calendar Year 2020 to 2021.

3. Recommendation—Compliance Review
c. Identify any barriers to implementing initiatives: • No barriers identified at this time.
HSAG Assessment: HSAG determined that Amerigroup Iowa partially addressed the prior recommendations. While Amerigroup Iowa indicated that its CAPs required by external audits are monitored by its corporate compliance team, Amerigroup Iowa should consider an internal evaluation to determine if the CAP sufficiently remediated all deficiencies. Additionally, as some of Amerigroup Iowa's CAPs were not yet completed at the time of the subsequent compliance review, HSAG recommends that Amerigroup Iowa prioritize full implementation of those remaining action plans.

4. Recommendation—Network Adequacy Validation
HSAG recommended the following: • Amerigroup Iowa should conduct a root cause analysis to investigate whether the low percentage of provider uniform resource locators (URLs) reported is due to a lack of providers with websites or if there are ways Amerigroup Iowa could be proactive in obtaining this information from the providers.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • This is included in a related CAP from the Compliance Review Audit regarding Provider Directory requirements.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Corporate initiatives are focused on populating Provider Directory information.
c. Identify any barriers to implementing initiatives: • The Iowa Medicaid Universal Provider Enrollment Application does not request the provider website information.
HSAG Assessment: HSAG determined that Amerigroup Iowa partially addressed the prior recommendations. While corporate initiatives are focused on populating provider directory information, Amerigroup Iowa's response did not provide details into those initiatives for HSAG to fully review and assess.

5. Recommendation—Encounter Data Validation
HSAG recommended the following: • Amerigroup Iowa should work with DHS to reconcile the reporting of either denied or voided claims with the appropriate negative or positive numbers.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Amerigroup completed a pharmacy reconciliation project to correct paid amounts and dispensing fees which was the root cause of denied or voided claims.

5. Recommendation—Encounter Data Validation
• Amerigroup implemented a new Pharmacy Benefits Manager, IngenioRx, in October 2019. This implementation led to an improvement with reporting for all claims including denied and or voided claims.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Amerigroup is exceeding 99% for accuracy, completeness and timeliness post the IngenioRx implementation.
c. Identify any barriers to implementing initiatives: • At this time, there are no barriers. The State and Amerigroup meet weekly to address data quality issues, assign action owners responsible for follow up and track execution dates for encounter remediation.
HSAG Assessment: HSAG determined that Amerigroup Iowa addressed the prior recommendations.

6. Recommendation—CAHPS Analysis
HSAG recommended the following: • Amerigroup Iowa should identify the potential sources of parents'/caretakers' dissatisfaction and focus efforts on improving their overall health plan experiences via initiatives implemented through the MCO's QI program. Additionally, Amerigroup Iowa should widely promote the health plan experience results of members and parents/caretakers of child members to its contracted providers and staff and solicit feedback and recommendations to improve overall satisfaction with both Amerigroup Iowa and its contracted providers.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Amerigroup continues to closely monitor the "Voice of the Customer" (post call member survey) results on a monthly basis to identify the source of dissatisfaction. If a deficiency is noted, a manager follows up with the member to get to the root of their issue and try to ensure member satisfaction. Those results are then brought to our quarterly Service Quality Committee for analysis. It has been determined that the top two reasons for calls and dissatisfaction are Pharmacy and Transportation related. A switch to new vendors for both Pharmacy and Transportation has resulted in an overall increase in call satisfaction related to both pharmacy and transportation calls over time. • In order to widely promote CAHPS results and solicit feedback from stakeholders, Amerigroup has made numerous efforts. We presented the results of CAHPS to both our Quality Management Committee and Medical Advisory committee and solicited feedback from both, although no specific feedback was provided. We promoted CAHPS in the provider newsletter and added a new CAHPS Training for providers in which they can get CEUs [continuing education units] for attending that we promoted to providers. We recently initiated a text campaign to members that is a post-provider text survey which allows us to gain more real-time data about member satisfaction between CAHPS Surveys and target interventions accordingly. We are also initiating a CAHPS Proxy survey for members beginning in the fall of 2021. In order to widely promote our results to members, we are also in the process of adding a document summarizing our most recent CAHPS results to our member website.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Analysis of the results of the monthly "Voice of the Customer" survey completed by the National Call Center, identified the top two reasons for dissatisfaction as being related to Pharmacy and

6. Recommendation—CAHPS Analysis
Transportation. From the time period of July 1, 2020 through June 30, 2021 we have seen a significant improvement in our data through the "Voice of the Customer" survey. During this time period, Pharmacy-related issues saw an increase going from 82.6% to 93.8% call satisfaction. Transportation-related issues saw an increase as well, going from 81.1% to 87.8% satisfaction.
c. Identify any barriers to implementing initiatives: • COVID-19 presented in March 2020 and continues to persist.
HSAG Assessment: HSAG determined that Amerigroup Iowa addressed the prior recommendations. While the measure rate for *Rating of Health Plan* for the CCC population slightly increased, the rate remained at least 5 percentage points below the national average. Therefore, HSAG recommends that Amerigroup Iowa promote efforts to continue improving this measure rate.

Iowa Total Care, Inc.

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

1. Recommendation—Performance Improvement Projects
HSAG recommended the following: • Iowa Total Care should document the codes used to identify the population (i.e., HEDIS delivery value set codes) as well as the codes to identify exclusions (i.e., HEDIS non-live birth value set codes). Additionally, Iowa Total Care should address HSAG's feedback for all *Partially Met* scores in the next annual submission.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
• Iowa Total Care (ITC) addressed HSAG's 2020 Performance Improvement Project (PIP) feedback for all Partially Met scores in our 2021 PIP submission. ITC completed the annual PIP submission in August 2021 and the recommendation to include the codes was addressed in the submission.
• ITC used the NCQA HEDIS MY 2020 Volume 2 Technical Specifications and the following HEDIS MY 2020 Volume 2 Value Set Directories to identify the population and exclusions:
  • Deliveries Value Set
  • Non-live Births Value Set

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • ITC submitted baseline data in 2021; therefore, ITC does not meet the requirement to submit activities in the most recent 2021 PIP submission.
c. Identify any barriers to implementing initiatives: • ITC submitted baseline data in 2021; therefore, ITC does not meet the requirement to submit activities in the most recent 2021 PIP submission.
HSAG Assessment: HSAG determined that Iowa Total Care addressed the prior recommendations.

2. Recommendation—Validation of Performance Measures
HSAG recommended the following: • Iowa Total Care should continue its efforts to train case managers on the appropriate use of standard system fields for consistent documentation. Iowa Total Care should also continue its ongoing internal audits of case files to monitor training effectiveness.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Multi-faceted trainings were developed and delivered to LTSS Case Management staff initially and ongoing. These include the initial education provided to all case managers for data entry and

2. Recommendation—Validation of Performance Measures
consistency needs, as well as ongoing training sessions through bi-weekly statewide meetings, monthly case manager team meetings, and monthly 1:1 Management Meetings with case managers. All of these offer opportunities to educate and ensure system consistency. In addition, Managers audit their case management staff member files quarterly to ensure data consistency. Iowa Total Care (ITC) developed additional system reporting fields for ongoing monitoring of system consistencies in data entry by staff. LTSS policies and procedures were updated accordingly.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • ITC is able to track consistency within data systems via our data extraction pulls. This helps overall to support accuracy in reporting PMV values.
c. Identify any barriers to implementing initiatives: • The volume of case management staff can offer challenges in consistency, but ITC manages this through our auditing mechanism and data management reporting.
HSAG Assessment: HSAG determined that Iowa Total Care addressed the prior recommendations.

3. Recommendation—Compliance Review
HSAG recommended the following: • As Iowa Total Care was required to submit a CAP to remediate the deficiencies, Iowa Total Care should proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented, Iowa Total Care should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Iowa Total Care (ITC) will forward to the Iowa Medicaid Enterprises (IME) any ownership and control interest disclosures that are sent directly to the health plan at any time via our already established email processes. This process has been fully implemented as of 3/31/2021. • ITC began sending credentialing letters to organizational providers in September 2020, soon after HSAG identified this in our virtual site meeting. The letter date is used for reporting for all providers, as stated in #2, page 88, Policy CC.Cred.01. This issue was resolved and fully implemented on 9/14/2020. • ITC will comply with all organizational credentialing guidelines and standards of the accrediting body through which the MCO attains accreditation, as well as all State and Federal rules and regulations per policy CC.CRED.09. ITC will primary source verify Accreditation status for those Providers who attest to being accredited by organizations who have web query available. ITC will primary source verify licensure for all provider types that are available to obtain via web query of the Iowa Department of Inspections and Appeals (DIA). ITC fully implemented these changes on 2/28/2021.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In 2021, ITC has forwarded three ownership disclosers to Iowa DHS. The process is working smoothly. • Prior to sending the organizational credentialing letter there were two different processes for calculating the credentialing timeframe. Now that there is a consistent process between organizations and practitioners a single process for tracking, calculating and reporting turnaround time has been established.

3. Recommendation—Compliance Review
• Based on internal evaluation, ITC believes that changes related to this CAP have remediated all recommendations.
c. Identify any barriers to implementing initiatives: • There have been no identified barriers as all initiatives have been implemented.
HSAG Assessment: HSAG determined that Iowa Total Care addressed the prior recommendations.

4. Recommendation—Network Adequacy Validation
HSAG recommended the following: • Iowa Total Care should conduct a comprehensive review of its provider data and online directory to ensure that provider numbers are accurate and documented consistently in both data sources. • Iowa Total Care should work with its providers to obtain specific information related to each provider location's accommodations for members with physical disabilities. Subsequently, Iowa Total Care should update its online provider directory with accommodation documentation. • Iowa Total Care should conduct a root-cause analysis to investigate whether the low percentage reported is due to a lack of providers with websites or if Iowa Total Care could be proactive in obtaining URL information from its network providers.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • All provider records with multiple phone numbers listed have been reconciled to have a single phone number listed. This ensures that the same phone number listed in Portico is also the same phone number listed in the Provider Directory. Iowa Total Care is also conducting quarterly phone audits and utilizing LexisNexis data to validate phone number accuracy. • Iowa Total Care has launched a Provider Accessibility Initiative (PAI). The goal of the PAI is to improve member access and health outcomes. This is done by increasing the percentage of practitioner locations and services in our network that meet the minimum federal and state disability access standards. ITC is using multiple marketing strategies and targeted outreach to gather improved Accessibility information and to ensure that it displays in the provider directory. • ITC validated URLs of provider who did not supply the information and updated those that were identified as missing; however, URLs are not required for provider enrollment.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • ITC has updated 3,257 provider phone records since January 2021. These are records that had multiple phones listed, were identified as a wrong number through an audit or were updated by the provider. • ITC has received 393 responses to the PAI. These 393 providers now have detailed accessibility information available on the provider directory. There are now over 1,800 total records with some Accessibility information displaying in the provider directory. • ITC has added 193 hospital and Health System URLs and will continue this project with clinics and provider groups. There are now 2,897 records that display a website URL in the provider directory.
c. Identify any barriers to implementing initiatives: • Educating providers to only provide main scheduling phone number.

4. Recommendation—Network Adequacy Validation
• The PAI survey is lengthy and time consuming. Many providers are reluctant to fill out the survey. • URL is not a required field for enrollment.
HSAG Assessment: HSAG determined that Iowa Total Care addressed the prior recommendations.

5. Recommendation—Encounter Data Validation
HSAG recommended the following: • Iowa Total Care should work with its vendors to enhance monitoring metrics for encounter timeliness. Iowa Total Care may consider metrics based on the lag days between dates of service and the dates when encounters are submitted to DHS. • Iowa Total Care should follow up with DHS to confirm that the automation process has been implemented successfully.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Given providers do not have to submit claims at the time of service, there can be up to a 6-12 month delay prior to ITC receiving the claim itself. As a result, ITC measures the Encounter Timeliness performance by comparing the paid/denied date to the date the encounter is sent to the State. This accounts for any delay in submission by the provider. • ITC currently provides a Monthly Encounter Claim Reconciliation Report to the State each month. This records all the claims paid/denied in the previous month whose encounter is due to the State by the 20th of the current month. This same report is used to track timeliness of encounters across all vendors. Additionally, there are Encounter Lag reports created to understand the timeliness based on encounter status (i.e. Submitted, In Process, Not Submitted, etc.). Some vendors themselves also having tracking measures for encounter submission. Note: ITC recently moved to CVS Pharmacy so they are in the processing of developing their timeliness report given the recent implementation. • Medicare crossover automation was implemented on 4/17/2020. ITC's configuration log was shared on a weekly basis with IME. ITC has not seen any issues since implementation and Medicare Crossover claims are flowing thru the system correctly.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • ITC has always tracked encounter timeliness for SLA/KPI [service level agreement/key performance indicator] purposes. ITC has consistently achieved 99% - 100% of the Timeliness SLA since Go Live using the methodologies listed above in Section a.
c. Identify any barriers to implementing initiatives: • There are no barriers given these measurements existing today.
HSAG Assessment: HSAG determined that Iowa Total Care addressed the prior recommendations.

6. Follow-Up on Prior EQR Recommendations for PAHPs

From the findings of each PAHP's performance for the CY 2021 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Medicaid program. The recommendations provided to each PAHP for the EQR activities in the *Calendar Year 2020 External Quality Review Technical Report* are summarized in Table 6-1 and Table 6-2. The PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identifies performance improvement, and/or barriers identified are also provided in Table 6-1 and Table 6-2.

Delta Dental of Iowa

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

1. Recommendation—Performance Improvement Projects
HSAG recommended the following: • Delta Dental of Iowa should revisit its causal/barrier analysis to determine and clearly document appropriate barriers. Delta Dental of Iowa should also establish a process for evaluating each intervention and its impact on the study indicators to allow for continual refinement of improvement strategies. • Delta Dental of Iowa should develop active interventions that can be tracked and trended to determine their impact on the study indicator outcomes. The results should be used to guide decisions for QI efforts.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • DDIA has reviewed the causal/barrier analysis and prioritization of program barriers. The process to evaluate each quality improvement intervention is being reviewed within the QAPI subcommittees to continue developing strategies that impact the identified study indicators. As part of that process, systems level and provider level interventions are being created, rather than just relying on member level interventions. • DDIA has developed more active interventions by assigning control and intervention groups to more accurately track member data and the effect it has on the outcomes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Developing active interventions with control and interventions groups has subsequently allowed for a process to effectively evaluate each intervention and confidently determine whether the intervention was successful.
c. Identify any barriers to implementing initiatives: • Staff turnover and hiring additional staff is impacting the progress in this area.
HSAG Assessment: HSAG has determined that Delta Dental of Iowa has partially addressed the recommendations. While Delta Dental of Iowa indicated that it has developed active interventions, the CY 2021 PIP results indicated that Delta Dental of Iowa implemented passive interventions; therefore, HSAG

1. Recommendation—Performance Improvement Projects
continues to recommend that the PAHP develop active targeted interventions that can be tracked and trended to determine their impact on the study indicator outcomes.

2. Recommendation—Validation of Performance Measures
HSAG recommended the following: • Delta Dental of Iowa should continue to ensure that its members have timely access to appropriate dental preventive care and develop active interventions to positively impact measure rates and overall dental care for its members.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • DDIA continues to proactively reach out to newly eligible members and members who have not accessed services in the last six months. DDIA is developing strategies to recruit providers in low access areas and creating a provider incentive plan focused on increasing access to present to Iowa Medicaid Enterprise for approval.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • DDIA has credentialed Creighton Dental School to increase accessibility for members.
c. Identify any barriers to implementing initiatives: • The ability to receive approval from Iowa Medicaid on the provider incentive plan. • Contractual latitude to increase reimbursement rates and official guidance on member pay.
HSAG Assessment: HSAG has determined that Delta Dental of Iowa has addressed the recommendations. While Delta Dental of Iowa identified contractual barriers, HSAG recommends that the PAHP focus on initiatives that the PAHP can influence and implement independently from the State.

3. Recommendation—Compliance Review
HSAG recommended the following: • As Delta Dental of Iowa was required to submit a CAP to remediate the deficiencies, Delta Dental of Iowa should proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented, Delta Dental of Iowa should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies. • Delta Dental of Iowa should recruit Iowa providers to support the Iowa Medicaid program; for example, network providers can serve as members on Delta Dental of Iowa's QI committee or local dental advisory committee. • Delta Dental of Iowa should consider obtaining member feedback when developing a new ABD template. • Delta Dental of Iowa staff members should research and familiarize themselves with QAPI program requirements and best practices.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

3. Recommendation—Compliance Review
• DDIA's Government Programs team meets weekly to review progress on corrective action plan (CAP) interventions and address barriers to progress to ensure timely implementation will be achieved. • DDIA continues to use the Dental Advisory Group to share initiatives and receive feedback on program improvement projects. • DDIA has made revisions to the adverse benefit determination (ABD) template. Additional edits are being made to the template based on member and customer service representative feedback. • DDIA has collaborated with other Delta Dental Medicaid programs to share best practices and receives suggestions for improvement on a quarterly basis.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None identified by PAHP.
c. Identify any barriers to implementing initiatives: • DDIA continues to look for non-traditional venues to gather provider input on various Medicaid initiatives.
HSAG Assessment: HSAG has determined that Delta Dental of Iowa has partially addressed the recommendations. HSAG continues to recommend that Delta Dental of Iowa recruit Iowa providers to support the Iowa Medicaid program through membership and participation in Delta Dental of Iowa's QI Committee, as it was unclear if additional Iowa providers have become members of the QI Committee. HSAG further recommends that the PAHP continue to consider innovative methods to gather provider input on applicable Medicaid initiatives.

4. Recommendation—Network Adequacy Validation
HSAG recommended the following: • Delta Dental of Iowa should continue its recruitment efforts for dental specialty providers (endodontists, periodontists, and prosthodontists). The PAHP should consult with DHS for statewide opportunities to actively recruit specialty providers for the Iowa Medicaid managed care program.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The provider incentive plan will be submitted to IME and includes specialty providers. • DDIA continues to work on provider recruitment for all providers, but specifically specialty providers.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None identified by PAHP.
c. Identify any barriers to implementing initiatives: • DDIA continues to struggle with getting commitment with specialty providers to provide services to the DWP and DWP kids population at the reimbursement rate that is outlined in the contract.
HSAG Assessment: HSAG has determined that Delta Dental of Iowa addressed the prior recommendations; however, HSAG further recommends that the PAHP continue to assess gaps in its provider network and determine if additional interventions could be employed to educate and recruit providers.

5. Recommendation—Encounter Data Validation
HSAG recommended the following: • Delta Dental of Iowa should audit provider encounter data submissions for completeness and accuracy. Delta Dental of Iowa may consider developing provider education training regarding encounter data submissions, dental record documentation, and coding practices.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • DDIA provided education to providers via a monthly newsletter and the annual training to properly bill for place of service. Internal measures are in place to alert staff if information is submitted incorrectly. • DDIA also offers peer to peer with providers to discuss dental record documentation and coding practices. • As part of the DWP Kids implementation, provider training included best practices for claims submission, dental record documentation standards and coding practice examples.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None identified by PAHP.
c. Identify any barriers to implementing initiatives: • None identified by PAHP.
HSAG Assessment: HSAG has determined that Delta Dental of Iowa addressed the prior recommendations.

Managed Care of North America Dental

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

1. Recommendation—Performance Improvement Projects
HSAG recommended the following: • As Managed Care of North America Dental progresses to the second remeasurement, the PAHP should revisit the causal/barrier analysis process to determine whether barriers identified continue to be barriers and determine if any new barriers exist that require the development of active interventions. Managed Care of North America Dental should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • In the second remeasurement of MCNA's annual dental visit (ADV) performance improvement project (PIP), MCNA revisited the causal/barrier analysis process to confirm existing barriers as well as identify any new barriers. Through MCNA's Dental Advisory Committee (DAC) and Quality Improvement Committee (QIC), it was determined that the results of the barrier analysis remained consistent with the previous remeasurement period. In addition, MCNA continues to evaluate the effectiveness of each intervention by monitoring the outcomes on a monthly basis and reporting the results quarterly to the QIC. The second remeasurement barrier analysis and evaluation of intervention outcomes were also thoroughly documented in the 2021 PIP submission.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • MCNA did experience delays in implementing interventions due to COVID-19.
HSAG Assessment: HSAG has determined that Managed Care of North America Dental addressed the prior recommendations. The CY 2021 PIP results identified that the PAHP appeared to have used the same interventions implemented prior to the COVID-19 pandemic as opposed to revisiting the interventions to determine if they should be modified to mitigate barriers associated with the pandemic.

2. Recommendation—Validation of Performance Measures
HSAG recommended the following: • Managed Care of North America Dental should conduct a root cause analysis or focused study to determine why its members were not accessing timely dental care in alignment with the performance measure standards established by DHS. Upon identification of a root cause, Managed Care of North America Dental should implement appropriate interventions to improve member access, which in turn should result in improved performance measure results. • Managed Care of North America Dental should conduct a root cause analysis or focused study to determine why a portion of its members were not receiving preventive dental care at least once during at least six months of continuous enrollment. Upon identification of a root cause, Managed Care of North America Dental should implement appropriate interventions to improve the performance of these measures.

2. Recommendation—Validation of Performance Measures
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • MCNA conducted a root cause analysis to determine why members are not accessing timely dental care and preventive care and the primary cause is the lack of oral health literacy among the member population. In response, MCNA did implement outbound call campaigns, text messaging, and member mailings to educate the member on the importance of routine dental care and preventive services and encourage them to schedule an appointment with their dental provider.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Interventions targeting selective cohorts significantly improved scores but the pandemic continues to limit demonstrable improvement for the population at large.
c. Identify any barriers to implementing initiatives: • MCNA did experience delays in implementing interventions due to COVID-19.
HSAG Assessment: HSAG has determined that Managed Care of North America Dental has addressed the prior recommendations; however, HSAG further recommends that the PAHP continue efforts to implement initiatives to improve member outcomes.

3. Recommendation—Compliance Review
HSAG recommended the following: • As Managed Care of North America Dental was required to submit a CAP to remediate the deficiencies, Managed Care of North America Dental should proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented, Managed Care of North America Dental should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies. • While the DAC includes three dental providers, Managed Care of North America Dental should continue to recruit providers of different specialties located in the State to support the DAC and the Iowa Medicaid program.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • MCNA has implemented all CAP interventions to remediate each deficiency. Much of the CAPs required that MCNA update its policy and procedure to ensure compliance with the requirements. The Compliance Department confirms that all policy and procedure updates have been made and implemented and validates continued compliance through its internal auditing process. • MCNA continues to recruit providers of different specialties in the State to support our Dental Advisory Committee (DAC). In the past CY, two additional providers have been recruited to include Pediatric, bringing our DAC membership to five.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A • The addition of providers with a Pediatric specialty allows for MCNA to share initiation specific to the children's population and receive feedback from providers that serve this specific population.

3. Recommendation—Compliance Review
c. Identify any barriers to implementing initiatives: • N/A • There were no barriers to this initiative.
HSAG Assessment: HSAG has determined that Managed Care of North America Dental has addressed the prior recommendations.

4. Recommendation—Network Adequacy Validation
HSAG recommended the following: • Managed Care of North America Dental should continue its recruitment efforts for dental specialty providers (endodontists, periodontists, and prosthodontists). The PAHP should consult with DHS for statewide opportunities to actively recruit specialty providers for the Iowa Medicaid managed care program.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • MCNA continues to collaborate with the Department of Human Services (DHS) to identify additional providers in areas with exceptionally long drive times. MCNA understands the need to recruit and enroll specialists, including endodontics, periodontics, and prosthodontics in rural areas of the state. Our Network Development team outreaches non-contracted providers at minimum 3 times per year to determine if there is any interest in participation. In 2020, MCNA utilized DHS's Provider Master File, this file includes all the providers enrolled, including those that have submitted claims for Medicaid fee service patients. We will continue utilizing this file to reach out to providers who have not contracted with MCNA in an attempt to recruit such providers.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result, providers were identified on the Master Provider File and additional providers have contracted including the following specialists: - 1 Endodontic - 5 Oral Surgeons - 6 Orthodontist - 11 Pediatric Dentist - 1 Prosthodontist
c. Identify any barriers to implementing initiatives: • We continue to encounter significant challenges and barriers to recruiting additional Endodontic, Periodontic and Prosthodontic providers in the state of IA per information gathered from our recruitment efforts: 1. Limited number of specialists in the state of IA, specifically in rural areas 2. Low reimbursement – specialists believe that the fees are too low 3. Regulatory requirements are burdensome
HSAG Assessment: HSAG has determined that Managed Care of North America Dental has addressed the prior recommendations; however, the PAHP should continue its efforts to contract with specialty providers and further develop strategies to overcome identified barriers for provider recruitment.

5. Recommendation—Encounter Data Validation
HSAG recommended the following: • Managed Care of North America Dental should work with its contracted providers to ensure that they comply with record procurement requirements. • Managed Care of North America Dental should audit provider encounter data submissions for completeness and accuracy. Managed Care of North America Dental may consider developing provider education training regarding encounter data submissions, dental record documentation, and coding practices.
MCP's Response (Note—The narrative within the MCP's Response section was provided by the MCP and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Record procurement requirements are outlined in MCNA's provider manual. Our provider manual is available on our website to all contracted providers. The manual is reviewed annually to ensure record procurement requirements are current and up to date with Medicaid requirements. • MCNA audits providers encounter data submissions on a regular basis for completeness and accuracy. When concerns for completeness, accuracy or lack of record documentation are identified, provider education is provided.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Audits of providers encounter data allowing for providers to receive fewer claim denials to ensure prompt payment.
c. Identify any barriers to implementing initiatives: • There have been no barriers to this initiative.
HSAG Assessment: HSAG determined that Managed Care of North America Dental has addressed the prior recommendations.

7. MCP Comparative Information

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

EQR 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.

Performance Improvement Projects

For the CY 2021 validation, the MCOs submitted the PIP Design and baseline data for two DHS-mandated PIP topics initiated in 2020, *Timeliness of Postpartum Care* and *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*. For the CY 2021 validation, the PAHPs submitted Remeasurement 2 data for their ongoing PAHP-specific PIP topics.

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

Table 7-1—Comparison of PIP Validation by MCP

MCP	Overall PIP Validation Status		Design and Implementation 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*	100%	0%	0%
ITC	*Timeliness of Postpartum Care*	*Met*	89%	5%	5%
ITC	*CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*	*Not Met*	76%	5%	19%
DDIA	*Annual Dental Visits*	*Not Met*	70%	20%	10%
MCNA	*Increase the Percentage of Dental Services*	*Not Met*	90%	0%	10%

* Percentage totals may not equal 100 due to rounding.

The validation status for the MCPs receiving an overall *Not Met* validation score was related to one or more critical elements not receiving a *Met* score, which impacted the overall validation status. Additionally, for the 2021 PAHP PIP validation, achieving statistically significant improvement was a DHS-approved critical element. For Remeasurement 2, both PAHPs demonstrated statistically significant decreases as compared to the baseline rates; therefore, their PIPs received a *Not Met* validation status.

Performance Measure Validation

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

Table 7-2—SFY 2021 Performance Measure #1a Rates—MCO Comparison

Performance Measure 1a					
Percentage of Eligible Members with Applicable Percentage of Authorized Services Utilized	**0%**	**1–49%**	**50–74%**	**75–89%**	**90–100%**
AGP	12.02%	42.43%	22.53%	10.78%	12.23%
ITC	8.69%	59.61%	17.65%	4.92%	9.13%

Table 7-3—SFY 2021 Performance Measure #1b Rates—MCO Comparison

Performance Measure 1b	
The Percentage of Eligible Members for Whom 100 Percent of HCBS Services Documented in Members' Care Plans had a Corresponding Approved Service Authorization	**Rate**
AGP	79.61%
ITC	89.03%

Table 7-4—SFY 2021 Performance Measure #2a, 2b, and 2c Rates—MCO Comparison

Performance Measure		MCO	
		AGP	**ITC**
2a	*Members With One or More Documented Care Plan One-Time Service*	2.28%	0.35%
2b	*Members With Documented Care Plan One-Time Service With Corresponding Approved Service Authorization*	36.36%	100.00%
2c	*Percentage of Authorized One-Time Services Utilized*	58.82%	75.00%

Table 7-5—SFY 2021 Performance Measure #3, #4, #5, and #6 Rates—MCO Comparison

Performance Measure		MCO	
		AGP	ITC
3	*Provision of Care Plan*	44.83%	83.92%
4	*Person-Centered Care Plan Meeting**	70.67%	94.73%
5	*Care Team Lead Chosen by the Member*	72.30%	96.46%
6	*Member Choice of HCBS Settings*	95.73%	95.82%

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

Table 7-6 displays the HEDIS MY 2020 rates for the MCOs.

Table 7-6—SFY 2021 (MY 2020) HEDIS Rates—MCO Comparison

Measures	Amerigroup HEDIS MY 2020 Rate	Iowa Total Care HEDIS MY 2020 Rate
Access to Preventive Care		
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	80.59% ★★★	77.47% ★★
45–64 Years	85.27% ★★	85.78% ★★
65 Years and Older	78.06% ★	81.78% ★
Use of Imaging Studies for Low Back Pain		
Use of Imaging Studies for Low Back Pain	70.97% ★	69.46% ★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	72.02% ★★	69.83% ★
Counseling for Nutrition—Total	65.69% ★★	61.56% ★
Counseling for Physical Activity—Total	61.07% ★★	55.72% ★
Women's Health		
Breast Cancer Screening		
Breast Cancer Screening	53.59% ★★	NA NC

Measures	Amerigroup HEDIS MY 2020 Rate	Iowa Total Care HEDIS MY 2020 Rate
Cervical Cancer Screening		
Cervical Cancer Screening	60.10% ★★	49.64% ★
Chlamydia Screening in Women		
Total	44.86% ★	45.61% ★
Non-Recommended Cervical Cancer Screening in Adolescent Females		
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.21% ★★★★	0.61% ★★★
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	78.10% ★	69.59% ★
Postpartum Care	68.86% ★	72.51% ★★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	89.54% ★★★	85.64% ★
HbA1c Control (<8.0%)	46.47% ★★	38.93% ★
*HbA1c Poor Control (>9.0%)**	42.34% ★★	50.12% ★
Blood Pressure Control (<140/90 mm Hg)	72.26% NC	65.21% NC
Eye Exam (Retinal) Performed	55.47% ★★	51.82% ★
Controlling High Blood Pressure		
Controlling High Blood Pressure	65.69% NC	62.53% NC
Statin Therapy for Patients With Cardiovascular Disease		
Received Statin Therapy—Total	81.21% ★★★	NA NC
Statin Therapy for Patients With Diabetes		
Received Statin Therapy	68.81% ★★★★	NA NC
Behavioral Health		
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	70.55% ★★	43.47% ★

Measures	Amerigroup HEDIS MY 2020 Rate	Iowa Total Care HEDIS MY 2020 Rate
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% ★	73.54% ★
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence		
7 Day Follow-Up—Total	46.06% ★★★★★	44.17% ★★★★★
30 Day Follow-Up—Total	53.41% ★★★★★	50.95% ★★★★★
Follow-Up After ED Visit for Mental Illness		
7-Day Follow-Up—Total	64.60% ★★★★	61.36% ★★★★
30-Day Follow-Up—Total	75.90% ★★★★★	72.48% ★★★★
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	48.83% ★★★★	30.72% ★★
30-Day Follow-Up—Total	69.37% ★★★★	50.94% ★★
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total	69.95% ★★★★★	76.18% ★★★★★
Engagement of AOD Treatment—Total	26.21% ★★★★★	28.41% ★★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Blood Glucose and Cholesterol Testing–Total	23.12% ★	20.76% ★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
Total	58.96% ★★	59.16% ★★
Keeping Kids Healthy		
Childhood Immunization Status		
Combination 3	75.43% ★★★★	70.07% ★★
Combination 10	51.58% ★★★★	41.36% ★★★
Immunizations for Adolescents		
Combination 1	88.81% ★★★★	84.18% ★★★

Measures	Amerigroup HEDIS MY 2020 Rate	Iowa Total Care HEDIS MY 2020 Rate
Combination 2	31.39% ★★	28.71% ★
Lead Screening in Children		
Lead Screening in Children	82.00% ★★★★	77.62% ★★★
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	46.91% NC	34.58% NC
Well-Child Visits for Age 15 Months-30 Months—Two or More Well-Child Visits	70.09% NC	60.51% NC
Child and Adolescent Well-Care Visits		
Total	45.54% NC	38.02% NC
Medication Management		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.62% ★★★	60.76% ★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	52.94% ★★	55.31% ★★★
Effective Continuation Phase Treatment	37.41% ★★	40.78% ★★★
Appropriate Testing for Pharyngitis		
Total	80.59% ★★★	80.22% ★★★
Appropriate Treatment for Upper Respiratory Infection		
Total	85.99% ★★	86.54% ★★
Asthma Medication Ratio		
Total	66.94% ★★★	NA NC
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis		
Total	47.06% ★★	51.14% ★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	42.87% ★★	54.49% ★★★★
Continuation and Maintenance Phase	45.50% ★	61.19% ★★★

Measures	Amerigroup HEDIS MY 2020 Rate	Iowa Total Care HEDIS MY 2020 Rate
Persistence of Beta-Blocker Treatment After a Heart Attack		
Persistence of Beta-Blocker Treatment After a Heart Attack	78.28% ★★	67.78% ★
Pharmacotherapy Management of COPD Exacerbation		
Systemic Corticosteroid	74.41% ★★★	42.43% ★
Bronchodilator	83.39% ★★	49.03% ★
Statin Therapy for Patients With Cardiovascular Disease		
Statin Adherence 80%—Total	72.84% ★★★	NA NC
Statin Therapy for Patients With Diabetes		
Statin Adherence 80%	70.34% ★★★★	NA NC
Use of Opioids at High Dosage*		
Use of Opioids at High Dosage	2.64% ★★★★	2.25% ★★★★
Use of Opioids From Multiple Providers*		
Multiple Prescribers	16.59% ★★★	15.87% ★★★★
Multiple Pharmacies	1.40% ★★★★★	1.64% ★★★★★
Multiple Prescribers and Multiple Pharmacies	1.04% ★★★★	1.22% ★★★★

* For this indicator, a lower rate indicates better performance.
NC Indicates that a comparison is not appropriate, or the prior year's rate was unavailable.
HEDIS MY 2020 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★ = At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Delta Dental of Iowa and Managed Care of North America Dental both received the rate designation of *Reportable* for all performance measures. Table 7-7 displays the rates for the PAHPs.

Table 7-7—SFY 2021 Performance Measure Rates—PAHP Comparison

Performance Measure		Measure Rates	
		DDIA	MCNA
2	*Members Who Accessed Dental Care*	30.97%	18.57%
3	*Members Who Received Preventive Dental Care*	75.49%	65.11%
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])*	54.79%	34.31%

* Performance measure #6 includes three distinct components.

Compliance Review

HSAG calculated the Iowa Medicaid managed care program overall performance in each of the seven performance areas reviewed during the CY 2021 compliance review. Table 7-8 presents the results of the MCPs that supported the Iowa Medicaid managed care program. Additionally, Table 7-8 compares the Iowa Medicaid managed care program average compliance score in each of the seven performance areas with the compliance score achieved by each MCP. As the MCO and PAHP scores were used to calculate the Iowa Medicaid managed care program results, all MCP results are presented. Table 7-8 also displays the remaining seven of the 14 standards that will be reviewed during the CY 2022 review cycle.

Table 7-8—Summary of Current Three-Year Cycle of Compliance Review Results

Year	Standard	Federal Standards and Associated Citations[1]	MCOs		PAHPs		Iowa Medicaid Managed Care Program
			AGP	ITC	DDIA	MCNA	
CY 2021	Standard I—Disenrollment: Requirements and Limitations	§438.56	100%	71%	100%	100%	92%
CY 2021	Standard II—Member Rights and Member Information	§438.100	80%	90%	82%	88%	85%
CY 2021	Standard III—Emergency and Poststabilization Services	§438.114	100%	100%	70%	100%	93%
CY 2021	Standard IV—Availability of Services	§438.206	100%	89%	100%	100%	97%
CY 2021	Standard V—Assurances of Adequate Capacity and Services	§438.207	100%	100%	100%	100%	100%

Year	Standard	Federal Standards and Associated Citations[1]	MCOs		PAHPs		Iowa Medicaid Managed Care Program
			AGP	ITC	DDIA	MCNA	
CY 2021	Standard VI—Coordination and Continuity of Care	§438.208	90%	100%	100%	86%	94%
CY 2021	Standard VII—Coverage and Authorization of Services	§438.210	80%	80%	90%	100%	88%
CY 2022	Standard VIII—Provider Selection	§438.214	—	—	—	—	—
CY 2022	Standard IX—Confidentiality	§438.224	—	—	—	—	—
CY 2022	Standard X—Grievance and Appeal Systems	§438.228	—	—	—	—	—
CY 2022	Standard XI—Subcontractual Relationships and Delegation	§438.230	—	—	—	—	—
CY 2022	Standard XII—Practice Guidelines	§438.236	—	—	—	—	—
CY 2022	Standard XIII—Health Information Systems[2]	§438.242	—	—	—	—	—
CY 2022	Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	—	—	—	—	—
Total Compliance Score for CY 2021			**90%**	**90%**	**89%**	**95%**	**91%**

Standard to be reviewed during the CY 2022 compliance review activity.

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

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

Readiness Review

As the PAHP readiness review was a one-time activity to assess each PAHP's readiness to successfully manage the DWP Kids population effective July 1, 2021, a comparative analysis of the results is not applicable. Both PAHPs demonstrated adequate readiness through HSAG's comprehensive assessment.

Network Adequacy Validation

Table 7-9, Table 7-10, Table 7-11, Table 7-12, and Table 7-13 show the rates of telehealth utilization for the MCOs' members.

Table 7-9—Percentage of Members Using Telehealth Services

MCO	Rate of MCO Members Using Telehealth	Weighted Rate of MCO Members Using Telehealth[1]
AGP	22.8%	24.1%
ITC	21.2%	22.6%
Statewide	**22.5%**	**23.6%**

[1] Rates are weighted by duration of enrollment in CY 2020.

Table 7-10—Use of Telehealth Services by Member Demographics—Age

MCO	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
AGP			
0–18	49.6%	37.7%	38.0%
19–21	5.0%	4.9%	4.9%
22–44	26.0%	33.6%	33.3%
45–64	14.8%	20.4%	20.5%
65+	4.6%	3.4%	3.3%
ITC			
0–18	46.6%	34.5%	34.9%
19–21	5.0%	4.9%	4.9%
22–44	28.3%	37.2%	36.8%
45–64	15.3%	20.3%	20.4%
65+	4.9%	3.1%	3.1%
Statewide			
0–18	47.9%	36.4%	36.9%
19–21	5.0%	4.9%	4.9%
22–44	27.2%	35.1%	34.6%
45–64	15.1%	20.4%	20.4%
65+	4.8%	3.3%	3.2%

Note: MCO percentages may not total 100.0% due to rounding.

[1] Proportions are weighted by duration of enrollment in CY 2020.

Table 7-11—Use of Telehealth Services by Member Demographics—Sex

MCO	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
AGP			
Female	54.8%	59.0%	59.2%
Male	45.2%	41.0%	40.8%
ITC			
Female	54.5%	58.9%	59.1%
Male	45.5%	41.1%	40.9%
Statewide			
Female	54.7%	59.0%	59.1%
Male	45.3%	41.0%	40.9%

Note: MCO percentages may not total 100.0% due to rounding.
[1] Proportions are weighted by duration of enrollment in CY 2020.

Table 7-12—Use of Telehealth Services by Member Demographics—Race

MCO	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
AGP			
American Indian or Alaska Native	0.4%	0.5%	0.4%
Asian	1.7%	0.7%	0.7%
Black or African American	7.4%	6.0%	6.0%
Native Hawaiian and Other Pacific Islander	0.6%	0.5%	0.5%
Some Other Race	6.5%	4.0%	4.0%
Two or More Races	3.7%	3.7%	3.7%
Unknown Race	29.2%	23.9%	23.8%
White	50.6%	60.8%	60.9%
ITC			
American Indian or Alaska Native	0.3%	0.4%	0.3%
Asian	1.9%	0.9%	0.9%
Black or African American	8.2%	6.5%	6.5%
Native Hawaiian and Other Pacific Islander	0.6%	0.5%	0.5%
Some Other Race	6.8%	4.3%	4.3%

MCO	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
Two or More Races	3.7%	3.8%	3.8%
Unknown Race	28.5%	23.4%	23.2%
White	49.9%	60.3%	60.4%
Statewide			
American Indian or Alaska Native	0.4%	0.4%	0.4%
Asian	1.8%	0.8%	0.8%
Black or African American	7.8%	6.2%	6.2%
Native Hawaiian and Other Pacific Islander	0.6%	0.5%	0.5%
Some Other Race	6.6%	4.1%	4.1%
Two or More Races	3.7%	3.7%	3.7%
Unknown Race	28.9%	23.7%	23.6%
White	50.3%	60.6%	60.7%

Note: MCO percentages may not total 100.0% due to rounding.
[1] Proportions are weighted by duration of enrollment in CY 2020.

Table 7-13—Use of Telehealth Services by Member Geography

MCO	Proportion of MCO Members	Proportion of MCO Members Using Telehealth	Weighted Proportion of MCO Members Using Telehealth[1]
AGP			
Rural	24.6%	22.2%	22.2%
Urban	75.4%	77.8%	77.8%
ITC			
Rural	23.5%	21.2%	21.2%
Urban	76.5%	78.8%	78.8%
Statewide			
Rural	24.1%	21.8%	21.8%
Urban	75.9%	78.2%	78.2%

Note: MCO percentages may not total 100.0% due to rounding.
[1] Proportions are weighted by duration of enrollment in CY 2020.

Table 7-14 and Table 7-15 show results from the PAHP disruptions analysis.

Table 7-14 illustrates the number of active providers in the FFS network (i.e., providers with at least one FFS encounter between July 1, 2019, and December 30, 2020) who were also enrolled in a PAHP to provide services to DWP Kids members after the transition of that program from FFS to managed care.

Table 7-14—Percentage of Providers in FFS and PAHPs' DWP Kids Provider Networks

Provider Category	Unique FFS Network[1]	DDIA		MCNA	
		Providers In-Network[2]	Percentage of FFS Network Providers in DDIA Network[3]	Providers In-Network[2]	Percentage of FFS Network Providers in MCNA Network[3]
Endodontist	5	5	100%	4	80%
General Dentist	1117	814	72.87%	326	29.19%
Oral Surgeon	66	48	72.73%	22	33.33%
Orthodontist	60	43	71.67%	13	21.67%
Pedodontist	48	40	83.33%	21	43.75%
Periodontist	4	4	100%	2	50%
Prosthodontist[4]	—	—	NA	—	NA
Provider Category Unknown[5]	487	20	4.11%	16	3.29%

[1] The number of unique provider NPIs with an FFS encounter between July 1, 2019, and December 30, 2020.
[2] The number of unique provider NPIs with an FFS encounter between July 1, 2019, and December 30, 2020, that were contracted in each respective PAHP's network.
[3] The rate of providers from the FFS network who were found in each respective PAHP's network.
[4] There were no providers who submitted an FFS encounter that had a Provider Category of Prosthodontist.
[5] Providers with an FFS encounter whose provider information was not available are identified as Provider Category Unknown.

As DWP Kids members transitioned from the FFS program to managed care, HSAG assessed their access to providers within DHS' minimum time and distance standards. Table 7-15 shows the percentage of members residing within the time and distance specified by contract standards for general dentists and whether the contract standard was met, stratified by PAHP and urbanicity (i.e., urban and rural). DHS established contract standards for the maximum allowable driving distance or driving time that members may travel to receive care from general dentists. PAHPs must ensure that 100 percent of their Medicaid members have access to dental providers within 30 miles or 30 minutes for members living in urban areas and 60 miles and 60 minutes for members living in rural areas.

Table 7-15—Percentage of Members With Access to General Dentists Within the Time and Distance Standards

PAHP	Percentage of Members With Access to General Dentists Within the Time Distance Standards	
	Rural (60 Miles or 60 Minutes)	Urban (30 Miles or 30 Minutes)
DDIA	100.0%	100.0%
MCNA	100.0%	98.37%

As part of the disruption analysis, HSAG assessed how many members may have experienced a disruption in their care due to the change from FFS to managed care. For this analysis, a disruption occurs when a member had a previous encounter with a provider who is not available in the member's newly assigned PAHP. In these instances, the member would have needed to find a new provider. This analysis included all provider types and members who had at least one FFS encounter with a dental provider between July 1, 2019, and December 30, 2020. Table 7-16 illustrates the number of members who transitioned from FFS to managed care and are now part of DWP Kids, and the number of those members who experienced at least one disruption in their care. Approximately 85 percent of Delta Dental of Iowa and Managed Care of North America members with at least one FFS encounter likely experienced a disruption in dental care.

Table 7-16—Number of Members Included in the Disruption Analysis

PAHP	Total Number of Members[1]	Total Number of Eligible Members With an FFS Encounter	Total Number of Eligible Members With an Encounter and Disruption
DDIA	171,517	74,826	63,240
MCNA	126,651	48,591	41,317

HSAG assessed the acceptance of new patients as another dimension of disruption that may affect DWP Kids members. Table 7-17 shows the total number of provider locations in urban and rural areas for Delta Dental of Iowa and Managed Care of North America. Managed Care of North America had fewer provider locations in rural areas, which may affect access to care for members in rural areas.

Table 7-17—Number of Provider Locations by Provider Type and PAHP

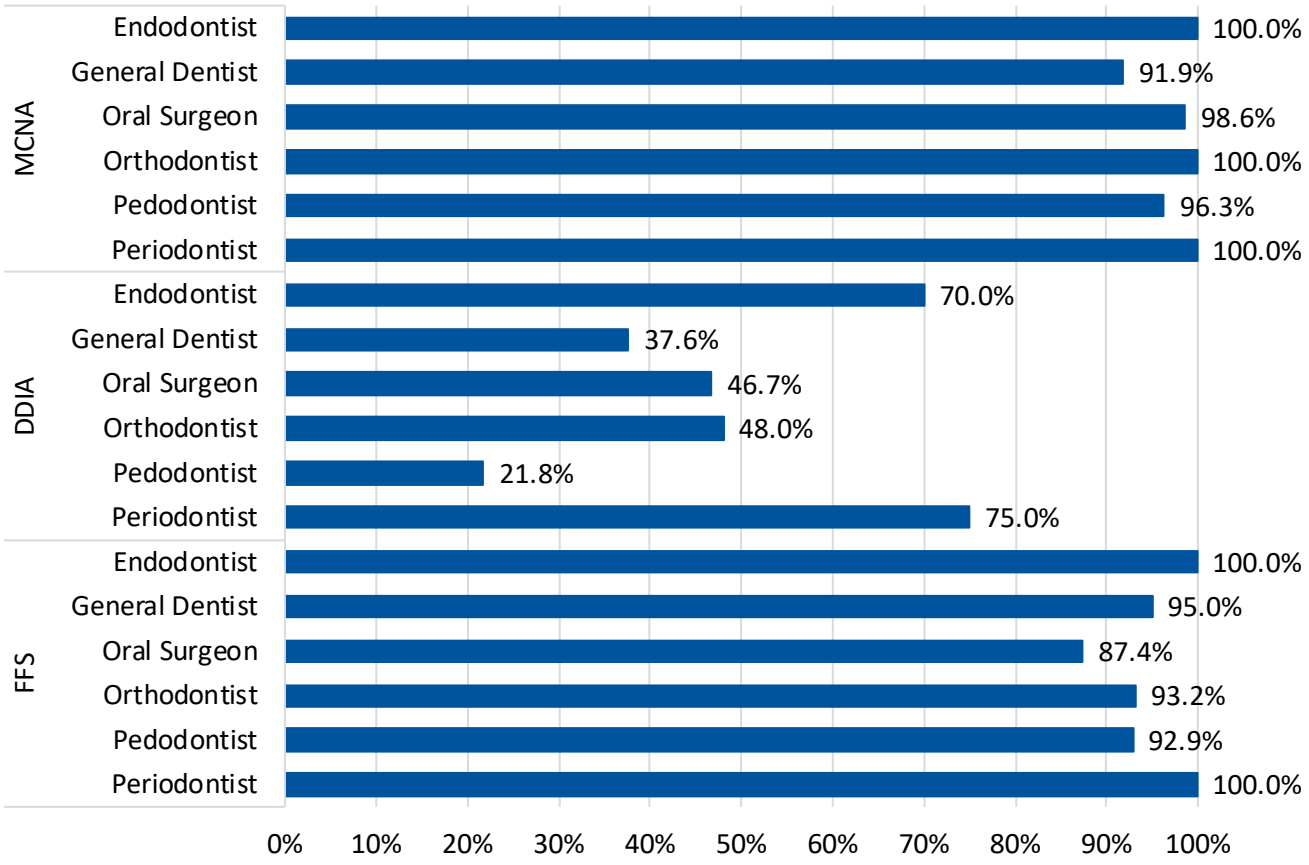
Provider Category	DDIA	MCNA
	Number of Unique Provider Locations	Number of Unique Provider Locations
Urban		
Endodontist	10	11
General Dentist	886	729

Provider Category	DDIA	MCNA
	Number of Unique Provider Locations	Number of Unique Provider Locations
Oral Surgeon	158	69
Orthodontist	86	26
Pedodontist	152	82
Periodontist	11	12
Prosthodontist	20	21
Rural		
Endodontist	—	—
General Dentist	304	70
Oral Surgeon	11	4
Orthodontist	14	2
Pedodontist	4	—
Periodontist	1	—
Prosthodontist	1	—

"—" indicates that the PAHP did not report any provider locations for that provider category in the urbanicity.

Figure 7-1 displays the percentage of providers who were accepting new patients for each provider category, PAHP, and FFS. For Managed Care of North America, over 90 percent of providers for all provider categories were accepting new patients, compared to Delta Dental of Iowa, where the percentage of providers accepting new patients ranged from 21.8 percent for pedodontists to 75.0 percent for periodontists. While Delta Dental of Iowa may have reported a smaller percentage of providers accepting new patients, it also reported more providers. Members' access to care is likely based on a combination of both the number of providers and the percentage of providers who will accept new patients.

Figure 7-1—Percentage of Providers who Report Accepting New Patients



Encounter Data Validation

Table 7-18 displays the percentage of records present in the files submitted by the MCOs that were not found in the DHS-submitted files (record omission), and the percentage of records present in the DHS-submitted files but not present in the MCO-submitted files (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 7-18—Record Omission and Surplus Rates by MCO and Encounter Type

MCO	Professional Encounters		Institutional Encounters		Pharmacy Encounters	
	Omission	Surplus	Omission	Surplus	Omission	Surplus
AGP	0.4%	0.3%	1.9%	1.9%	5.3%	0.4%
ITC	5.0%	5.3%	10.0%	0.5%	9.6%	0.0%
Overall	**1.9%**	**1.9%**	**4.7%**	**1.4%**	**6.8%**	**0.3%**

Table 7-19 displays the element omission, element surplus, and element absent results for each key data element from the professional encounters. For the element omission and surplus indicators, lower rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 7-19—Data Element Omission, Surplus, and Absent: Professional Encounters

Key Data Elements	Element Omission			Element Surplus			Element Absent		
	Overall	AGP	ITC	Overall	AGP	ITC	Overall	AGP	ITC
Member ID	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Detail Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Detail Service To Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Billing Provider NPI	**0.0%**	0.0%	0.0%	**3.8%**	4.1%	3.2%	**<0.1%**	<0.1%	<0.1%
Rendering Provider NPI	**0.0%**	0.0%	0.0%	**46.1%**	48.5%	40.7%	**<0.1%**	<0.1%	<0.1%
Referring Provider NPI[A]	**0.7%**	<0.1%	2.2%	**<0.1%**	<0.1%	<0.1%	**62.1%**	63.9%	58.3%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	**<0.1%**	0.0%	<0.1%	**0.0%**	0.0%	0.0%
Secondary Diagnosis Code[A]	**<0.1%**	<0.1%	<0.1%	**3.8%**	0.0%	12.2%	**53.1%**	54.1%	51.0%
CDT/CPT/HCPCS Procedure Code	**0.0%**	0.0%	0.0%	**<0.1%**	0.0%	<0.1%	**0.0%**	0.0%	0.0%
Procedure Code Modifier[A]	**<0.1%**	<0.1%	<0.1%	**<0.1%**	<0.1%	<0.1%	**54.0%**	53.1%	55.9%
Units of Service	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
NDC[A]	**<0.1%**	<0.1%	<0.1%	**<0.1%**	<0.1%	0.0%	**97.2%**	98.6%	94.2%
Detail Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%

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

Table 7-20 displays the element omission, element surplus, and element absent results for each key data element from the institutional encounters. For the element omission and element surplus indicators, lower rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 7-20—Data Element Omission, Surplus, and Absent: Institutional Encounters

Key Data Elements	Element Omission			Element Surplus			Element Absent		
	Overall	AGP	ITC	Overall	AGP	ITC	Overall	AGP	ITC
Member ID	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Header Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Header Service To Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Admission Date[A]	**<0.1%**	<0.1%	0.0%	**1.5%**	2.2%	0.0%	**78.9%**	81.1%	74.3%

Key Data Elements	Element Omission			Element Surplus			Element Absent		
	Overall	AGP	ITC	Overall	AGP	ITC	Overall	AGP	ITC
Billing Provider NPI	**0.0%**	0.0%	0.0%	**0.2%**	0.0%	0.6%	**0.0%**	0.0%	0.0%
Attending Provider NPI	**0.6%**	1.0%	0.0%	**0.0%**	0.0%	0.0%	**0.1%**	<0.1%	0.1%
Referring Provider NPI[A]	**<0.1%**	0.0%	0.1%	**0.1%**	0.0%	0.4%	**98.7%**	99.3%	97.4%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	**<0.1%**	<0.1%	0.0%	**0.0%**	0.0%	0.0%
Secondary Diagnosis Code[A]	**<0.1%**	<0.1%	<0.1%	**<0.1%**	0.0%	<0.1%	**18.1%**	18.4%	17.7%
CDT/CPT/HCPCS Procedure Code[A]	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**17.2%**	16.8%	18.1%
Procedure Code Modifier[A]	**<0.1%**	0.0%	<0.1%	**<0.1%**	0.0%	<0.1%	**76.9%**	76.4%	77.8%
Units of Service	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Primary Surgical Procedure Code[A]	**0.9%**	0.5%	1.6%	**0.4%**	0.6%	0.0%	**94.7%**	95.1%	93.9%
Secondary Surgical Procedure Code[A]	**0.6%**	0.4%	1.1%	**0.3%**	0.4%	0.0%	**96.6%**	96.9%	96.2%
NDC[A]	**0.1%**	0.2%	<0.1%	**0.2%**	0.2%	<0.1%	**91.1%**	91.5%	90.2%
Revenue Code	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
DRG Code[A]	**<0.1%**	<0.1%	<0.1%	**1.4%**	2.1%	0.2%	**91.1%**	91.6%	90.1%
Header Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Detail Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%

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

Table 7-21 displays the element omission, element surplus, and element absent results for each key data element from the pharmacy encounters. For the element omission and element surplus indicators, lower rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 7-21—Data Element Omission and Surplus: Pharmacy Encounters

Key Data Elements	Element Omission			Element Surplus			Element Absent		
	Overall	AGP	ITC	Overall	AGP	ITC	Overall	AGP	ITC
Member ID	**0.0%**	0.0%	0.0%	**<0.1%**	<0.1%	0.0%	**0.0%**	0.0%	0.0%
Header Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%
Billing Provider NPI	**0.0%**	0.0%	0.0%	**<0.1%**	<0.1%	0.0%	**0.0%**	0.0%	0.0%
Prescribing Provider NPI	**<0.1%**	0.0%	<0.1%	**<0.1%**	<0.1%	0.0%	**0.0%**	0.0%	0.0%

Key Data Elements	Element Omission			Element Surplus			Element Absent		
	Overall	AGP	ITC	Overall	AGP	ITC	Overall	AGP	ITC
NDC	**<0.1%**	<0.1%	0.0%	**<0.1%**	<0.1%	0.0%	**0.0%**	0.0%	0.0%
Drug Quantity	**0.0%**	0.0%	0.0%	**<0.1%**	<0.1%	0.0%	**0.0%**	0.0%	0.0%
Header Paid Amount	**0.0%**	0.0%	0.0%	**<0.1%**	<0.1%	0.0%	**0.0%**	0.0%	0.0%
Dispensing Fee	**0.0%**	0.0%	0.0%	**<0.1%**	<0.1%	0.0%	**0.0%**	0.0%	0.0%

Table 7-22 displays percentage of records with the same values (i.e., element accuracy) in the MCO-submitted files and the DHS-submitted files for each key data element associated with the professional encounters. For the element accuracy indicator, higher rates indicate better performance.

Table 7-22—Data Element Accuracy: Professional Encounters

Key Data Element	Element Accuracy		
	Overall	AGP	ITC
Member ID	**>99.9%**	100.0%	>99.9%
Detail Service From Date	**>99.9%**	>99.9%	>99.9%
Detail Service To Date	**99.9%**	99.8%	>99.9%
Billing Provider NPI	**99.9%**	100.0%	99.6%
Rendering Provider NPI	**99.7%**	99.6%	>99.9%
Referring Provider NPI	**>99.9%**	100.0%	>99.9%
Primary Diagnosis Code	**97.6%**	100.0%	92.5%
Secondary Diagnosis Code	**97.9%**	>99.9%	92.1%
CDT/CPT/HCPCS Procedure Code	**>99.9%**	>99.9%	>99.9%
Procedure Code Modifier	**>99.9%**	>99.9%	>99.9%
Units of Service	**97.9%**	97.1%	99.6%
NDC	**99.9%**	99.7%	100.0%
Detail Paid Amount	**99.5%**	99.3%	99.9%

Table 7-23 displays percentage of records with the same values (i.e., element accuracy) in the MCO-submitted files and the DHS-submitted files for each key data element associated with the institutional encounters. For the element accuracy indicator, higher rates indicate better performance.

Table 7-23—Data Element Accuracy: Institutional Encounters

Key Data Element	Element Accuracy		
	Overall	AGP	ITC
Member ID	**>99.9%**	100.0%	>99.9%

Key Data Element	Element Accuracy		
	Overall	AGP	ITC
Header Service From Date	**98.6%**	97.9%	>99.9%
Header Service To Date	**97.7%**	96.6%	>99.9%
Admission Date	**98.3%**	97.1%	>99.9%
Billing Provider NPI	**>99.9%**	100.0%	>99.9%
Attending Provider NPI	**100.0%**	100.0%	100.0%
Referring Provider NPI	**100.0%**	100.0%	100.0%
Primary Diagnosis Code	**>99.9%**	100.0%	>99.9%
Secondary Diagnosis Code	**>99.9%**	>99.9%	>99.9%
CDT/CPT/HCPCS Procedure Code	**100.0%**	100.0%	100.0%
Procedure Code Modifier	**>99.9%**	100.0%	>99.9%
Units of Service	**88.9%**	90.5%	85.6%
Primary Surgical Procedure Code	**>99.9%**	>99.9%	100.0%
Secondary Surgical Procedure Code	**99.9%**	100.0%	99.8%
NDC	**97.4%**	96.3%	99.3%
Revenue Code	**100.0%**	100.0%	100.0%
DRG	**57.7%**	>99.9%	<0.1%
Header Paid Amount	**97.0%**	95.7%	99.6%
Detail Paid Amount	**99.0%**	98.8%	99.5%

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

Table 7-24—Data Element Accuracy: Pharmacy Encounters

Key Data Element	Element Accuracy		
	Overall	AGP	ITC
Member ID	**>99.9%**	>99.9%	99.9%
Header Service From Date	**100.0%**	100.0%	100.0%
Billing Provider NPI	**99.9%**	>99.9%	99.9%
Prescribing Provider NPI	**>99.9%**	>99.9%	>99.9%

Key Data Element	Element Accuracy		
	Overall	AGP	ITC
NDC	**99.9%**	99.9%	99.8%
Drug Quantity	**96.4%**	96.5%	96.2%
Header Paid Amount	**>99.9%**	>99.9%	100.0%
Dispensing Fee	**99.3%**	98.9%	100.0%

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

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

MCO	Professional Encounters	Institutional Encounters	Pharmacy Encounters
AGP	94.9%	85.4%	95.3%
ITC	79.3%	88.4%	95.8%
Overall	**90.0%**	**86.4%**	**95.5%**

Encounter Data Completeness

Table 7-26 displays the PAHPs and overall results for the number of encounter records received and processed monthly.

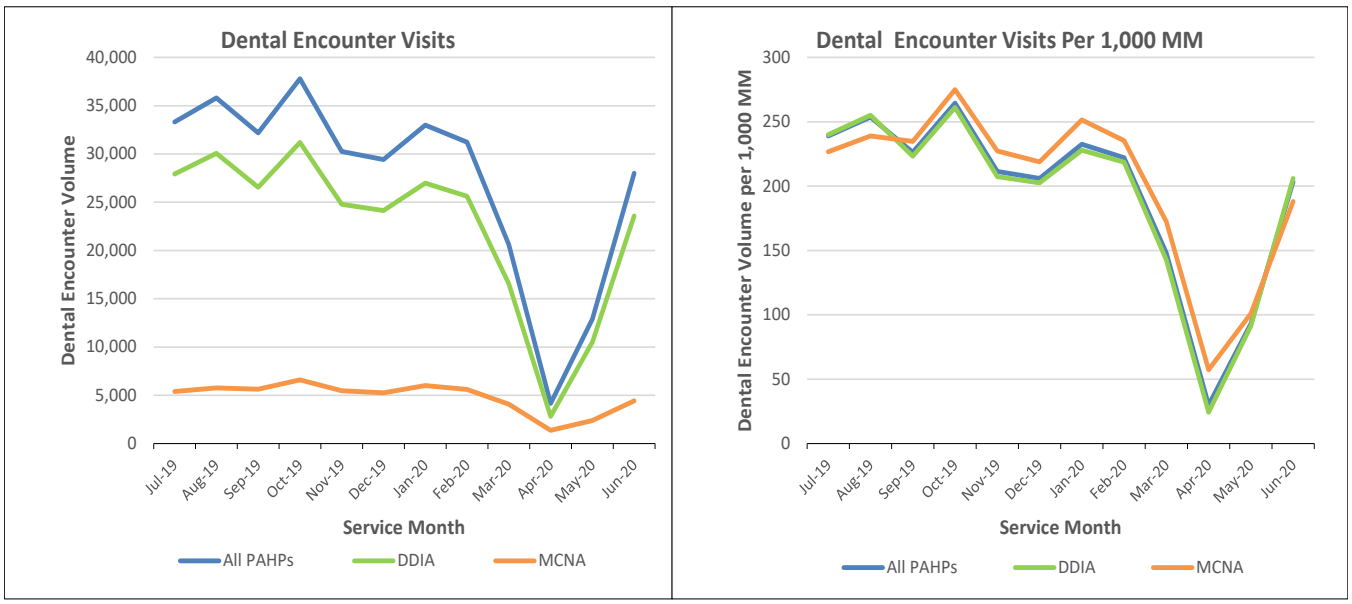
Table 7-26—Dental Encounter Record Counts by MMIS Month

MMIS Month	Overall	DDIA	MCNA
July 2019	1,168	0	1,168
August 2019	71,009	56,919	14,090
September 2019	98,389	82,510	15,879
October 2019	105,496	83,156	22,340
November 2019	128,857	110,170	18,687
December 2019	106,541	88,567	17,974
January 2020	69,981	55,773	14,208
February 2020	85,949	62,422	23,527
March 2020	140,367	118,551	21,816
April 2020	85,105	72,391	12,714
May 2020	30,494	24,065	6,429
June 2020	32,298	21,884	10,414
July 2020	88,992	77,959	11,033

MMIS Month	Overall	DDIA	MCNA
August 2020	43,150	42,596	554
September 2020	4,074	3,600	474
October 2020	3,180	2,758	422
November 2020	2,042	1,784	258
December 2020	1,849	1,665	184
January 2021	1,562	1,368	194
February 2021	1,776	1,264	512
March 2021	2,017	946	1,071
April 2021	4	0	4
Total	**1,104,300**	**910,348**	**193,952**

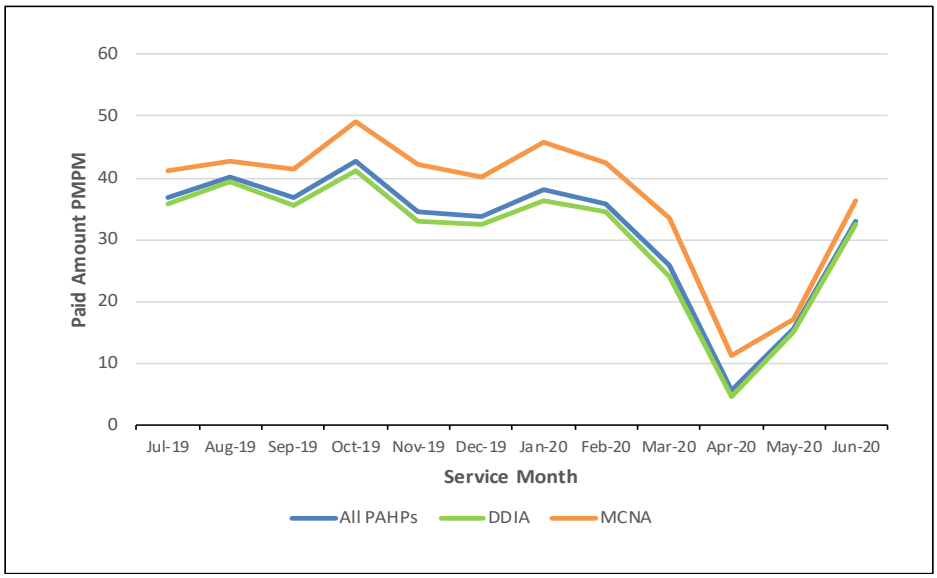
Figure 7-2 displays the dental encounter visit/service counts by service month and visit/service counts per 1,000 MM.

Figure 7-2—Dental Encounter Visits and Encounter Visits per 1,000 MM



The final measure describes the dental encounter completeness based on paid amounts by service month as displayed in Figure 7-3.

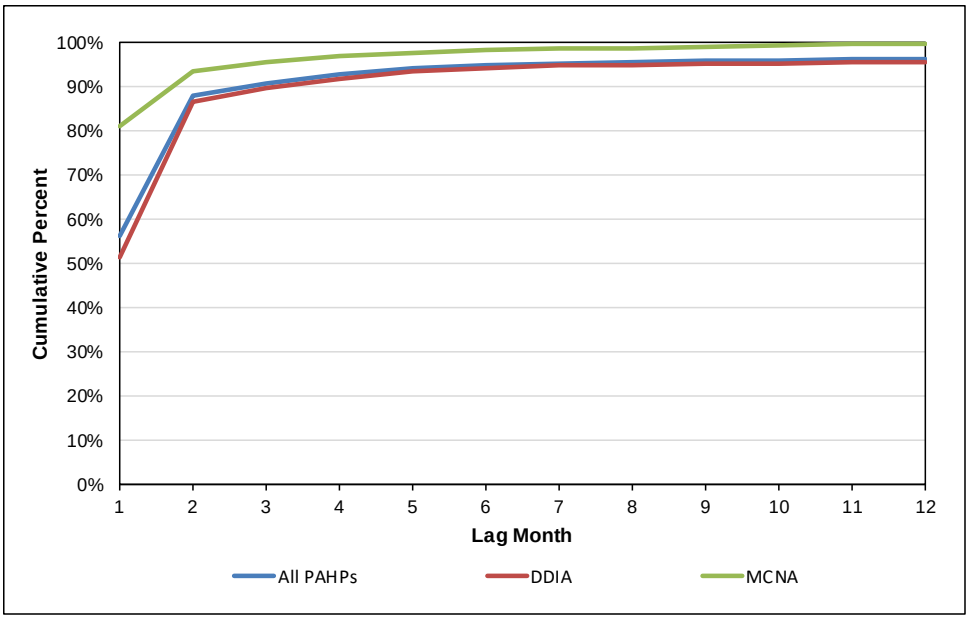
Figure 7-3—Paid Amounts PMPM by Service Month



Encounter Data Timeliness

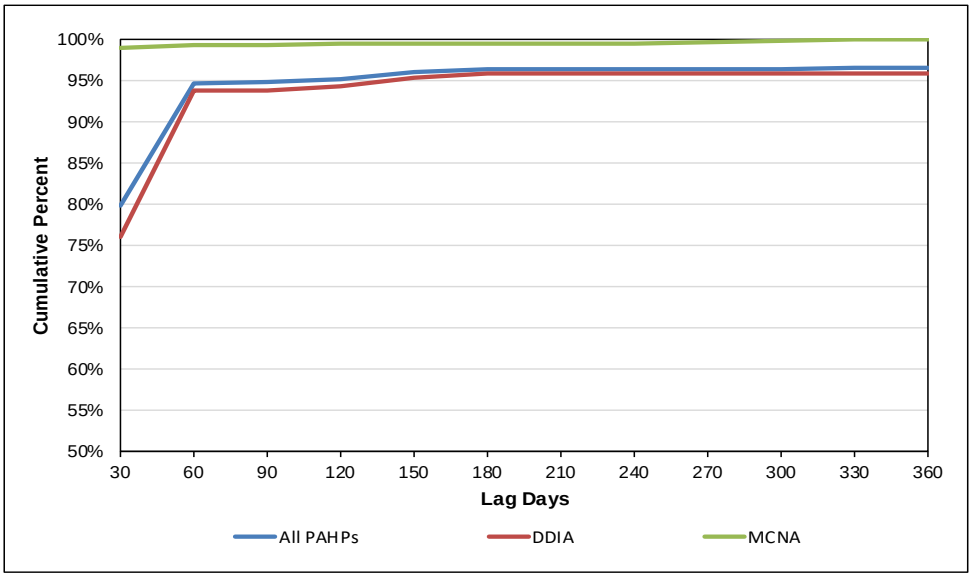
The first timeliness study indicator evaluates the lag between the date of service (e.g., data element detail line first date of service) and MMIS processed date. Figure 7-4 displays the cumulative percentage of records processed by MMIS within specified days from the dates of service by monthly intervals.

Figure 7-4—Cumulative Percentage of Dental Encounters Accepted Into DHS' MMIS Since the Date Services Were Rendered



The second timeliness measure evaluates the lag days between the PAHP paid date and the MMIS date. This timeliness metric is used to evaluate how soon the PAHPs submit encounters to DHS after their internal processes. Figure 7-5 displays the cumulative percentage of records processed by MMIS within specified days from the payment date. Please note that cumulative percentage starts at 50 percent for the figure, as more than 50 percent of records were processed within 30 days of the PAHP payment date.

Figure 7-5—Cumulative Percentage of Dental Encounters Accepted Into DHS' MMIS Since PAHP Payment Date



Field-Level Completeness and Accuracy

HSAG evaluated key data elements to determine the completeness and accuracy of DHS' dental encounter data., Results from this analysis identified gaps in the completeness of certain data fields and potential issues with data validity and/or integrity with other datasets. Table 7-27 displays the results for the key data elements in the dental encounter data.

Table 7-27—Dental Encounter Data Element Completeness and Accuracy

Data Element	Overall		DDIA		MCNA	
	Percent Present	Percent Valid	Percent Present	Percent Valid	Percent Present	Percent Valid
Member ID[1]	100.0%	99.7%	100.0%	99.6%	100.0%	99.9%
Header First Date of Service[1]	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service[1]	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Detail First Date of Service[2]	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Detail Last Date of Service[2]	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Paid Date[2]	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Billing Provider NPI[1]	100.0%	92.2%	100.0%	91.7%	100.0%	95.0%

Data Element	Overall		DDIA		MCNA	
	Percent Present	Percent Valid	Percent Present	Percent Valid	Percent Present	Percent Valid
Rendering Provider NPI[1]	100.0%	99.4%	100.0%	99.3%	100.0%	>99.9%
Primary Diagnosis Code[1]	2.3%	100.0%	0.0%	NA	14.0%	100.0%
CDT/CPT/HCPCS Code(s)[2]	100.0%	>99.9%	100.0%	>99.9%	100.0%	>99.9%
Tooth Number[2]	27.1%	>99.9%	25.5%	>99.9%	34.7%	100.0%
Surface Code(s)[2]	3.5%	100.0%	1.8%	100.0%	11.4%	100.0%
Oral Cavity Code(s)[2]	3.1%	100.0%	3.1%	100.0%	3.0%	100.0%

[1] Analyses were performed at the header level.
[2] Analyses were performed at the line level.

Consumer Assessment of Healthcare Providers and Systems Analysis

HSAG compared each MCO's and the MCO program's (i.e., Amerigroup Iowa and Iowa Total Care combined) results to the 2020 NCQA national averages to determine if the results were 5 percentage points higher or lower than the 2020 NCQA national averages. Arrows in the tables note a change of 5 percentage points or more. A green upward arrow (↑) indicates a top-box score that was at least 5 percentage points greater than the 2020 NCQA national average. Conversely, a red downward arrow (↓) indicates a top-box score that was at least 5 percentage points less than the 2020 NCQA national average. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as NA.

Table 7-28 and Table 7-29 present the 2021 top-box scores for Amerigroup Iowa and Iowa Total Care compared to the top-box scores of the MCO program for the adult and child Medicaid populations, respectively.

Table 7-28—2021 MCO Adult CAHPS Comparisons

	AGP	ITC	MCO Program
Composite Measures			
Getting Needed Care	88.1% ↑	88.8% ↑	88.5% ↑
Getting Care Quickly	84.7%	89.3% ↑	86.8%
How Well Doctors Communicate	95.8%	96.3%	96.0%
Customer Service	NA	NA	91.6%
Global Ratings			
Rating of All Health Care	62.3%	60.8%	61.6%
Rating of Personal Doctor	73.3%	78.4% ↑	75.7% ↑

	AGP	ITC	MCO Program
Rating of Specialist Seen Most Often	68.5%	65.0%	66.8%
Rating of Health Plan	65.4%	66.9%	66.1%
Effectiveness of Care Measures*			
Advising Smokers and Tobacco Users to Quit	70.8% ↓	NA	71.4% ↓
Discussing Cessation Medications	43.1% ↓	NA	46.9% ↓
Discussing Cessation Strategies	39.5% ↓	NA	43.0% ↓

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as "NA."
* The scores for AGP follow NCQA's methodology of calculating a rolling two-year average. However, the scores for ITC deviates from NCQA's methodology, since only one year of CAHPS data are available.
↑ Indicates the 2021 score is at least 5 percentage points greater than the 2020 national average.
↓ Indicates the 2021 score is at least 5 percentage points less than the 2020 national average.

Table 7-29—2021 MCO Child CAHPS Comparisons[7-1]

	AGP	ITC	MCO Program
Composite Measures			
Getting Needed Care	90.9%	NA	90.3%
Getting Care Quickly	90.0%	NA	90.5%
How Well Doctors Communicate	96.0%	96.4%	96.1%
Customer Service	89.9%	NA	88.7%
Global Ratings			
Rating of All Health Care	74.6%	73.9%	74.4%
Rating of Personal Doctor	81.6%	80.8%	81.4%
Rating of Specialist Seen Most Often	76.8%	NA	76.1%
Rating of Health Plan	68.5%	69.6%	68.8%

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."
↑ Indicates the 2021 score is at least 5 percentage points greater than the 2020 national average.
↓ Indicates the 2021 score is at least 5 percentage points less than the 2020 national average.

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

Quality Rating

DHS contracted with HSAG in 2021 to develop a scorecard to evaluate the performance of Iowa Medicaid MCOs. The Iowa scorecard demonstrates how the MCOs compare to national benchmarks in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 7-30. Please refer to Appendix A for the detailed methodology used for this tool.

Table 7-30—Iowa Scorecard Results—MCO Scorecard Performance Ratings

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

Table 7-31 displays the 2021 Iowa Scorecard results for each MCO.

Table 7-31—2021 Iowa Scorecard Results

MCO	Doctors' Communication and Patient Engagement	Access to Preventive Care	Women's Health	Living With Illness	Behavioral Health	Medication Management
AGP	★★★★	★★★	★★	★★★★	★★★★	★★★
ITC	★★★★	★★★	★★	★★	★★★	★★★★

For 2021, Amerigroup Iowa demonstrated the strongest performance by achieving High Performance for three of the five reporting categories (*Doctors' Communication and Patient Engagement*, *Living With Illness*, and *Behavioral Health*) and Average Performance for two of the five reporting categories (*Access to Preventive Care* and *Medication Management*). Iowa Total Care also demonstrated strong performance by achieving High Performance in two of the five reporting categories (*Doctors' Communication and Patient Engagement* and *Medication Management*) and Average Performance for two of the five reporting categories (*Access to Preventive Care* and *Behavioral Health*). Opportunities for improvement exist, with both MCOs having at least one reporting category that had a Low Performance rating.

Statewide Conclusions and Recommendations

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

Strengths

Through this all-inclusive assessment of aggregated performance, HSAG identified areas of strength in the program related to quality of, timeliness of, and access to care and services.

- **Quality**
  - Performance results for the *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measures demonstrate that the Iowa Medicaid managed care program is reducing the risk of opioid-related overdoses through appropriate and evidence-based prescribing practices. Individuals who receive opioid prescriptions through multiple providers, and at high dosages, are at greater risk of fatal and nonfatal overdoses. The rates for these performance measures suggest that the Iowa Medicaid managed care program is engaged in working with providers to limit access to habit-forming medications when not medically necessary. This finding is further supported through the MCOs' efforts to coordinate care for members diagnosed with alcohol or other drug dependence as supported by high-performing HEDIS measure rates and compliance review findings in this program area. This strength within the program supports DHS' progress in achieving the Iowa MCO Quality Strategy *Access to Care* goal of *increasing access to primary care and specialty care* and the *Behavioral Health* goal of *assessing the potential for a SUD Health Home Program*.
  - The aggregated adult CAHPS measure score for the Iowa Medicaid managed care program for *Getting Needed Care* was more than 5 percentage points above the national average, indicating that adult Iowa Medicaid managed care members had positive experiences when getting necessary care, tests, or treatments, and scheduling timely appointments with specialists. This strength of the program supports DHS' progress in achieving the Iowa MCO Quality Strategy *Access to Care* goal of *increasing access to primary care and specialty care* and the *Voice of the Customer* goal of *annually reviewing CAHPS results and making recommendations for improvement*.
  - Overall, statewide performance for the Coordination and Continuity of Care standard reviewed as part of the compliance review activity was high, indicating that the program has effective processes for ensuring that Iowa's Medicaid managed care members have access to care coordination and care management programs. Additionally, as demonstrated through the PMV

activity, Iowa Medicaid managed care members enrolled in a waiver program chose their current care setting, have a goal to live in a less restrictive setting, or were living in the least restrictive setting. This strength of the program supports DHS' progress in achieving the Iowa MCO Quality Strategy *Continuity of Care* goals of *ensuring the accuracy and completeness of member information needed to efficiently and effectively transition members between plans and/or providers*, *monitoring long-term care facility documentation to ensure that members choosing to live in the community are able to successfully transition to the community as well as remain in the community*, and *monitoring transition and discharge planning for LTSS members.* This strength further supports the *Improving Coordinated Care* goals of *70 percent of HRAs will be completed within 90 days of enrollment and annually thereafter*, *100 percent timely completion of level of care and needs-based eligibility assessments*, and *100 percent timely completion of the initial and annual service plan review and updates* and the Iowa PAHP Quality Strategy goal of *providing care coordination to members based on HRAs by monitoring of HRA completion for members continuously enrolled for six months*.

- **Timeliness**
  - Through the State-mandated PIP topic, *Timeliness of Postpartum Care*, the Iowa Medicaid managed care program is focusing efforts on engaging new mothers in accessing timely postpartum care. Postpartum care sets the stage for the health and wellbeing of mothers and babies, as new moms are at risk of serious and life-threatening health complications that can be prevented with timely and adequate postpartum care. Although the statewide performance for *Timeliness of Postpartum Care* is low, by implementing interventions to improve performance, the Iowa Medicaid managed care program is engaged in and focused on reducing the possibility of adverse health outcomes for both mothers and babies. This strength of the program supports DHS' progress in achieving the Iowa MCO Quality Strategy *Access to Care* goal of *improving timeliness of postpartum care* and the *Improving Coordinated Care* goal of *improving the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes.*
  - Performance results for *Follow-Up After ED Visit for AOD Abuse or Dependence*, *Follow-Up After ED Visit for Mental Illness*, and *Initiation and Engagement of AOD Abuse or Dependence Treatment* demonstrate that the Iowa Medicaid managed care program is engaged in providing timely follow-up treatment for members diagnosed with an SUD or a mental illness after an ED visit to improve physical and mental functions and reduce repeat ED visits, hospital admissions and readmissions, and healthcare spending. Additionally, due to the addition of telehealth services to the HEDIS MY 2020 measure specifications, high performance in these measures likely indicates a high adoption rate for telehealth services during the COVID-19 pandemic. This is further supported by the NAV activity, which identified that almost a quarter of Iowa's Medicaid managed care members accessed telehealth services in CY 2020. This strength within the program supports DHS' progress in achieving the Iowa MCO Quality Strategy *Behavioral Health* goal of *promoting behavioral health by measuring follow-up after hospitalization/follow-up after emergency department visit for pediatric and adult populations.* It further supports the Iowa MCO Quality Strategy *Decrease Cost of Care* goal of *reducing the rate of potentially preventable readmissions and non-emergent ED visits*.

- **Access**
  - As demonstrated through high performance in the Availability of Services and Assurances of Adequate Capacity and Services standards reviewed through the compliance review activity, the Iowa Medicaid managed care program has effective processes in place to maintain and monitor an adequate provider network that is sufficient to provide adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, LTSS, behavioral health, optometry, lab and x-ray, pharmacy, and dental) for the Medicaid managed care population. This strength of the program supports DHS' progress in achieving the Iowa MCO Quality Strategy Access to Care goal of improving network adequacy and the Iowa PAHP Quality Strategy goal of ensuring access to cost-effective healthcare through contract compliance by timely reviewing PAHP network adequacy reports. Additionally, as demonstrated through the NAV activity, MCO members were accessing telehealth services, and PAHP members had access to a sufficient network of general dentists in rural areas.

Weaknesses

HSAG's comprehensive assessment of the MCPs and the Iowa Medicaid managed care program also identified areas of focus that represent significant opportunities for improvement within the program related to quality of, timeliness of, and access to care and services.

- **Quality**
  - *Diabetes Monitoring for People With Diabetes and Schizophrenia*, *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications,* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing* are two of the lower-performing HEDIS measures statewide. These low rates indicate that Iowa Medicaid managed care members receiving behavioral health treatment using antipsychotic medications are not always being screened or monitored properly. Screening for 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. This weakness of the program supports the need for continued focus on the Iowa MCO Quality Strategy *Access to Care* goal of *increasing access to primary care and specialty care* and the *Behavioral Health* goal of *promoting mental health through the Integrated Health Home Program*.
  - As demonstrated through lower performance for the *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women* HEDIS measures, many women enrolled in Iowa's Medicaid managed care program are not being seen or screened by their providers. Breast cancer is one of the most common cancers among American women, while cervical cancer is one of the most common causes of cancer death for American women. Effective screening and detection can improve outcomes, reduce the risk of death, and lower healthcare costs. Further, untreated chlamydia infections can lead to serious and irreversible complications such as pelvic inflammatory disease and infertility. Additionally, as indicated by lower program performance in

the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* HEDIS measure and the Effectiveness of Care CAHPS measures, Iowa Medicaid contracted providers have opportunities to spend additional time educating members on maintaining healthy lifestyle habits, including proper nutrition, physical activity, and smoking and tobacco cessation strategies. Additionally, Iowa Medicaid contracted providers may be ordering unnecessary imaging studies for members experiencing low back pain and inappropriately treating upper respiratory infections with antibiotics as indicated through the related, lower-performing HEDIS measure indicators. Unnecessary or routine imaging for low back pain is not associated with improved outcomes and exposes members to unnecessary harms such as radiation. Also, inappropriate use of antibiotics has led to the development of antibiotic resistant bacteria and is ineffective in treating viral upper respiratory infections. This weakness of the program supports the need for continued focus on the Iowa MCO Quality Strategy *Access to Care* goal of *increasing access to primary care and specialty care*.

  - Overall, the Iowa Medicaid managed care program demonstrated lower performance for *Comprehensive Diabetes Care* HEDIS measure indicators, indicating that some adult Iowa Medicaid managed care members were not receiving proper diabetes management to help control their blood glucose and reduce the risk of complications related to diabetes. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. This weakness of the program supports the need for continued focus on the Iowa MCO Quality Strategy *Access to Care* goal of *increasing access to primary care and specialty care*.

- **Timeliness**
  - Lower performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* HEDIS measure indicators demonstrates that Iowa Medicaid managed care enrolled women are experiencing barriers to accessing prenatal and postpartum care. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants. While DHS has mandated the *Timeliness of Postpartum Care* PIP, which is an overall strength for the program, the lower performance of these measure indicators demonstrates a need for continued focus on quality initiatives to increase member access to timely prenatal and postpartum care through the PIP activity and/or other activities implemented through the MCOs' QAPI programs. While the initiation of the *Timeliness of Postpartum Care* PIP is an overall strength for the Iowa Medicaid managed care program, the lower performance for the *Prenatal and Postpartum Care* measure indicators supports the need for continued focus on the Iowa MCO Quality Strategy *Access to Care* goal of *improving timeliness of postpartum care* and the *Improving Coordinated Care* goal of *improving the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes.*
- **Access**
  - Although both adult and child members have access to dental benefits through the Iowa Medicaid managed care program and the PAHPs performed exceptionally well in the

Availability of Services and Assurances of Adequate Capacity and Services compliance review standards, some members are not obtaining adequate dental care, as demonstrated through lower-performing PAHP performance measure rates. While the *Members Who Received Preventive Dental Care* measure rate remained relatively stable, the rates for *Members Who Accessed Dental Care* and *Members Who Received a Preventive Examination and a Follow-Up Examination* declined. Additionally, neither PAHP reached its PIP goal for accessing dental services, and the study indicator measurement rates (*Annual Dental Visits* [Delta Dental of Iowa] and *Increase the Percentage of Dental Services* [Managed Care of North America Dental]) demonstrated statistically significant declines from the established baseline measurement period. The COVID-19 pandemic may have been a contributing factor to the lower rates; however, the PAHPs' PIP interventions were either passive and incomplete, or were not revisited to include challenges associated with the pandemic. Further, as demonstrated through the PAHP NAV activity, approximately 85 percent of DWP Kids members with at least one FFS encounter likely experienced a disruption in dental care when transitioning from FFS to managed care, which may present as a barrier to dental care. HSAG has determined that access to dental services is a weakness of the Iowa Medicaid managed care program over previous EQR years. This weakness of the program supports the need for enhanced focus on the Iowa PAHP Quality Strategy goals of *promoting appropriate utilization of services within acceptable standards of dental practice* and *ensuring access to cost-effective healthcare through contract compliance by incentivizing access to preventive dental services.*

– As demonstrated through overall lower performance in the Access to Preventive Care and Living With Illness HEDIS domains, Iowa Medicaid managed care members are not always accessing preventive services or getting screened and treated for chronic conditions. Specifically, accessing primary or specialty care services is critical to addressing acute issues and managing chronic conditions and is important for members to receive counseling for nutrition and physical activity to reduce risks related to untreated obesity. This weakness of the program supports the need for continued focus on the Iowa MCO Quality Strategy *Access to Care* goal of *increasing access to primary care and specialty care.*

Quality Strategy Recommendations for the Iowa Medicaid Managed Care Program

The Iowa Quality Strategy is designed to improve the health outcomes of Iowa's Medicaid members by continually improving the delivery of quality healthcare to all Medicaid and Hawki members served by the Iowa Medicaid managed care programs. DHS' Quality Strategy serves as a guidance document to oversee Iowa's Medicaid managed care programs and to explore the possibilities of using clinical outcome-based research in the development of a set of measures to complement existing systems. In consideration of the goals of the Quality Strategy and the comparative review of findings for all activities, HSAG recommends the following quality improvement initiatives, which target the identified specific goals within DHS' Quality Strategy.

Goal: *Access to Care*

- Increase access to primary care and specialty care

Goal: *Behavioral Health*

- Promote mental health through the Integrated Health Home Program
- Identify common behavioral health conditions, use of community services, follow-up care, and medication adherence

Goal: *Healthy Equity*

- Identify health disparities or inequities and target those areas for improvement

To improve program-wide performance in support of the *Access to Care* and *Behavioral Health* Quality Strategy goals and improve the quality of care provided to members by Iowa contracted network providers, including increasing the prevalence of recommended health screenings, education efforts around healthy living, and appropriate medication management for members with behavioral health and chronic conditions, HSAG recommends the following:

- **Initiate Provider Collaborative—**DHS should collaborate with the MCOs to develop strategies to increase provider adherence to nationally recognized best practices and clinical practice guidelines.
  - DHS/MCOs should identify focused areas for improvement using information published in the *IA Health Link Managed Care Annual Performance Report*[8-1] and this EQR Technical Report to target specific areas to address with Iowa contracted network providers. Examples of areas that could be focused on include appropriate screenings for the physical health needs of members diagnosed with mental health conditions; treatment of low back pain and upper respiratory infections; and member counseling on healthy lifestyle habits, including proper nutrition, physical activity, and smoking and tobacco cessation strategies.
  - DHS/MCOs could consider information-gathering efforts with high-volume, contracted providers to obtain information about gaps in member care and/or ineffective treatment options to better understand the provider perspective on why Iowa Medicaid members were not getting recommended screenings, counseling on healthy lifestyle habits, and appropriate treatment for certain conditions (e.g., low back pain and dual diagnoses of mental health/chronic conditions).
  - DHS could require the MCOs to analyze data to identify whether there are any health disparities or inequities in the areas of focus, and these data could be shared with the providers as part of the collaborative efforts. These disparities/inequities could include race, ethnicity, age, sex, member residence (urban versus rural), etc.
  - From the information gathered through the provider collaborations, DHS/MCOs could implement initiatives to reduce gaps in care and improve the quality of care.
- **Develop Quality of Care Outcomes Goal—**DHS should update its Quality Strategy to include a clinical outcomes goal that focuses on reducing gaps in care and supports member/provider adherence to effective treatment protocols.

[8-1] Iowa Department of Human Services, Iowa Medicaid Enterprise. *IA Health Link Managed Care Annual Performance Report (July 2019 – June 2020).* Available at: https://www.legis.iowa.gov/docs/publications/DF/1207563.pdf. Accessed on: Oct 27, 2021.

- As part of this goal development, DHS should consider assigning minimum performance benchmarks to a DHS-defined set of performance measures that pertain to quality of care and member health outcomes. Setting minimum performance benchmarks should incentivize the MCOs to focus efforts on improving quality of care for their members.
- DHS could consider whether an MCO pay-for-performance initiative would be an appropriate strategy to support program improvement in focused areas.

Goal: ***Access to Care***

- Improve network adequacy
- Improve timeliness of postpartum care
- Increase access to primary care and specialty care

Goal: ***Behavioral Health***

- Promote behavioral health by measuring *follow-up after hospitalization/follow-up after emergency department* visit for pediatric and adult populations
- Promote mental health through the Integrated Health Home Program
- Identify common behavioral health conditions, use of community services, follow-up care, and medication adherence

Goal: ***Decrease Cost of Care***

- Reduce the rate of potentially preventable readmissions and nonemergent ED visits

Goal: ***Improving Coordinated Care***

- Improve the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes

Goal: ***Healthy Equity***

- Identify health disparities or inequities and target those areas for improvement

Goal: ***Preventive Dental Services***

- Promote appropriate utilization of services within acceptable standards of dental practice
- Incentivize access to preventive dental services
- Promote healthcare quality standards in managed care programs by monitoring processes for improvement opportunities and assist PAHPs with implementation of improvement strategies
- Ensure data collection of race and ethnicity, as well as aid category, age, and gender in order to develop meaningful objectives for improvement in preventive and chronic dental care by focusing on specific populations
- Promote the use and interoperability of health information technology between providers, PAHPs, and Medicaid

To improve program-wide performance in support of the *Access to Care*, *Behavioral Health*, *Decrease Cost of Care*, *Improving Coordinated Care*, *Healthy Equity*, and *Preventive Dental Services* Quality Strategy goals and increase member access to medical and dental services, HSAG recommends the following:

- **Increase Telehealth Usage—**With NCQA specification updates to 40 HEDIS measures with new telehealth accommodations, DHS and the MCOs should develop initiatives to promote telehealth usage in older members and those living in rural areas, since those populations were identified as having lower usage.
  - DHS/MCOs should assess the barriers that prevent members from using telehealth services when telehealth is available.
  - After the barriers are identified, DHS and the MCOs should develop a collaborative to discuss appropriate strategies and interventions to implement program-wide to improve telehealth usage in older adults and for those members residing in rural locations.
  - DHS and the MCOs should evaluate whether telehealth usage is linked to improved performance measure rates and assess whether the implemented interventions or strategies for telehealth usage correlate to better health outcomes.
- **Dental PIP Intervention Mandate—**The dental PAHPs have initiated preventive dental services PIPs; however, there were noted concerns with the interventions that had been implemented, and performance measure rates remained low and decreased since CY 2019. Additionally, the PIPs did not consider any potential disparities or inequities that contributed to this low performance.
  - DHS should require the PAHPs to analyze their performance measure data related to member access to preventive dental services to determine if there are any disparities or inequities that exist within the member population not accessing preventive dental care.
  - Upon identification of the disparity/inequity (e.g., race, ethnicity, age, geographical location of residence), DHS should require the PAHPs to develop actionable interventions to support improvement and eliminate the disparity/inequity.
  - DHS should further require the PAHPs to regularly assess their interventions to determine if the interventions are effective at mitigating the disparity. DHS should also require the PAHPs to provide regular intervention progress updates to keep DHS informed of any barriers the PAHPs encounter to performance improvement.

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Performance Improvement Projects

Activity Objectives

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

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

For the MCOs' PIPs, HSAG used the CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[A-1] For the PAHPs' PIPs, HSAG used the CMS *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[A-2] because these PIPs were initiated in 2018. When the PAHPs implement new PIPs, HSAG will use the CMS publication, *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[A-3]

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

[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 17, 2021.

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: July 6, 2021.

[A-3] 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: July 6, 2021.

indicator(s), sampling methods, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that the reported PIP results are accurate and capable of measuring sustained improvement.

2. HSAG evaluates the implementation of the PIP. Once, designed, the PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the 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 study design and a clinician with expertise in performance improvement processes. HSAG, in collaboration with DHS, 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 MCO PIPs, HSAG, with DHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs per the CMS protocols. The CMS protocols identify nine steps that should be validated for each PIP.

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

Step I. Appropriate PIP Topic
Step II. Clearly Defined, Answerable Aim Statement(s)
Step III. Correctly Identified Population
Step IV. Sound Sampling Methods (if sampling was used)
Step V. Clearly Defined Performance Indicator(s)
Step VI. Valid and Reliable Data Collection
Step VII. Sufficient Data Analysis and Interpretation
Step VIII. Appropriate Improvement Strategies
Step IX. Real and sustained Improvement Achieved

For the PAHPs' PIPs, HSAG, with DHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs per the CMS protocol. The CMS protocol identify 10 steps that should be validated for each PIP. The 10 steps included in the PIP Validation Tool are listed below:

Step I. Appropriate Study Topic
Step II. Clearly Defined, Answerable Study Questions(s)
Step III. Correctly Identified Study Population
Step IV. Clearly Defined Study Indicator(s)

Step V. Valid Sampling Techniques (if sampling was used)
Step VI. Accurate and Complete Data Collection
Step VII. Sufficient Data Analysis and Interpretation
Step VIII. Appropriate Improvement Strategies
Step IX. Real Improvement Achieved
Step X. Sustained Improvement Achieved

HSAG used the following methodology to evaluate PIPs conducted by the 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 Comment with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP steps and evaluation elements.

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

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

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

The MCPs had an opportunity to resubmit a revised PIP Submission Form and additional information in response to HSAG's initial validation scores of *Partially Met* or *Not Met* and to address any General Comments, regardless of whether the evaluation element was critical or noncritical. HSAG conducted a

final validation for any resubmitted PIPs. HSAG offered technical assistance to any 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 DHS and the MCPs.

Description of Data Obtained and Related Time Period

For CY 2021, the MCOs submitted their PIP Design (Steps I through VI) and baseline 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 2 data (Steps I through VIII) for their PIP topics. The PAHPs used a modified HEDIS measure specification for the *Annual Dental Visits* PIP performance indicator specific to annual dental visits. Delta Dental of Iowa used a modified Form CMS-416 Annual Early and Periodic Screening, Diagnostic, and Treatment Participation Report measure specification for the *Annual Dental Visits* PIP performance indicator specific to preventive dental visits. 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	Study Question(s)	Sampling Techniques	Data Sources
Annual Dental Visits	1. Do targeted interventions increase the percentage of members 19 years and older who had at least one dental visit during the measurement year? 2. Do targeted interventions increase the percentage of members 1 to 18 years of age 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	Do targeted interventions increase the percentage of members 19 years and older who had at least one 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 displays the indicator measurement periods for all PIP topics for the MCPs.

Table A-3—MCO Measurement Periods for both 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	January 1, 2018—December 31, 2018
Remeasurement 1	January 1, 2019—December 31, 2019
Remeasurement 2	January 1, 2020—December 31, 2020

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 study'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., study indicator results compared to baseline, prior remeasurement period results, and study goal) and qualitative results (e.g., technical design of the PIP, data analysis, and implementation of improvement strategies) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCPs' Medicaid members.

Performance Measure Validation

Activity Objectives

The purpose of PMV is to assess the accuracy of performance measures reported by MCPs and to determine the extent to which performance measures reported by the MCPs follow State specifications

and reporting requirements. HSAG also followed the guidelines set forth in CMS' *EQR Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[A-4]

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

Technical Methods of Data Collection and Analysis

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

- **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 DHS-developed measures. HSAG reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance measures**—The 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 DHS. 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 DHS for validation.

In collaboration with DHS, HSAG prepared a documentation request letter that was submitted to the MCPs, which outlined the steps in the PMV process. The documentation request letter included a request for the source code for each performance measure, a completed ISCAT, and any additional supporting documentation necessary to complete the audit. The letter also included a timeline for

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 17, 2021.

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 MCOs with an agenda describing all review activities and indicated the type of staff needed for participation in each session. HSAG also conducted a pre-review conference call with the MCPs to discuss review logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the MCPs.

PMV Review Activities

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

- **Opening and organizational review**—This interview session included introductions of HSAG's validation team and key MCP staff involved in the support of the MCPs' information systems and its calculation and reporting of the performance measures. HSAG reviewed expectations for the virtual review, discussed the purpose of the PMV activity, and reviewed the agenda and general audit logistics. This session also allowed the MCPs to provide an overview of its organizational operations and any important factors regarding its information systems or performance measure activities.
- **Review of key information systems and data processes**—Drawing heavily on HSAG's desk review of the MCPs' ISCAT responses, these interview sessions involved key MCP staff responsible for maintaining the information systems and executing the processes necessary to produce the performance measure rates. HSAG conducted interviews to confirm findings based on its documentation review, expanded or clarified outstanding questions, and ascertained that written policies and procedures were used and followed in daily practice. Specifically, HSAG staff evaluated the systems and processes used in the calculation of selected performance measures.
  - **Enrollment, eligibility, provider, and claims/encounter systems and processes**—These evaluation activities included a review of key information systems and focused on the data systems and processes critical to the calculation of measures. HSAG conducted interviews with key staff familiar with the collection, processing, and monitoring of the MCP data used in producing performance measures.
  - **Overview of data integration and control procedures**—This session included a review of the database management systems' processes used to integrate key source data and the MCPs' calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
  - **System demonstrations**—HSAG staff requested that MCP staff demonstrate key information systems, database management systems, and analytic systems to support documented evidence and interview responses.
- **PSV**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output

information used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across evaluated measures to verify that the MCPs had appropriately applied measure specifications for accurate rate reporting. The MCPs provided HSAG with a listing of the data the MCPs had reported to DHS from which HSAG randomly selected a sample of cases and requested that the MCPs provide proof of service documentation. During the virtual review, these data were reviewed live in the MCPs' systems for verification. This approach enabled the MCPs to explain its processes regarding any exception processing or unique, case-specific nuances that may or may not impact final measure reporting.

Description of Data Obtained and Related Time Period

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- **Information Systems Capabilities Assessment Tool—**HSAG received this tool from each MCP. The completed ISCATs provided HSAG with background information on the MCPs'' policies, processes, and data in preparation for the virtual review validation activities.
- **Source Code (Programming Language) for Performance Measures—**HSAG obtained source code from each MCP (if applicable). If the MCPs did not produce source code to generate the performance indicators, the MCPs submitted a description of the steps taken for measure calculation from the point that the service was rendered through the final calculation process. HSAG reviewed the source code or process description to determine compliance with the performance indicator specifications provided by the MCPs.
- **Current Performance Measure Results—**HSAG obtained the calculated results from the MCPs.
- **Supporting Documentation—**This documentation provided additional information needed by HSAG reviewers to complete the validation process. Documentation included performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Virtual Interviews and Demonstrations—**HSAG also obtained information through discussion and formal interviews with key MCP staff members as well as through systems demonstrations.

Table A-5 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table A-5—Description of MCO Data Sources

Data Obtained	Time Period to Which the Data Applied	
	AGP	ITC
Completed ISCAT	SFY 2020 SFY 2021	SFY 2021
Source code for each performance measure		
Performance measure results		
Supporting documentation		
Virtual on-site interviews and systems demonstrations	June 29, 2021	June 28, 2021

Additionally, DHS provided HSAG with each MCO's audited HEDIS rates for DHS-selected measures, and HSAG reviewed the rates in comparison to national Medicaid percentiles to identify strengths and opportunities for improvement.

Table A-6 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table A-6—Description of PAHP Data Sources

Data Obtained	Time Period to Which the Data Applied	
	DDIA	MCNA
Completed ISCAT	SFY 2021	
Source code for each performance measure		
Performance measure results		
Supporting documentation		
Virtual on-site interviews and systems demonstrations	August 2, 2021	August 4, 2020

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that the MCPs provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, *Not Applicable*, or *Not Reported*. HSAG further analyzed the quantitative results (e.g., performance indicator results) and qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members.

Compliance Review

Activity Objectives

The objective of the compliance review activity was to assess each MCP's compliance with the federal compliance review standards outlined in 42 CFR §438.358(b)(1)(iii) and related State contract requirements. DHS and the MCP will use the information and findings that resulted from HSAG's review to:

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

Beginning in CY 2021, DHS requested that HSAG conduct compliance reviews over a new three-year cycle with one-half of the standards being reviewed in Year One and Year Two. In Year Three (CY

2023), HSAG will conduct a comprehensive review of each element scored as *Not Met* during Year One (CY 2021) and Year Two (CY 2022). The division of standards over the three years can be found in Table A-7.

Table A-7—Three-Year Cycle of Compliance Reviews

Standards	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard I—Disenrollment: Requirements and Limitations	✓		Review of MCP implementation of Year One and Year Two CAPs
Standard II—Member Rights and Member Information	✓		
Standard III—Emergency and Poststabilization Services	✓		
Standard IV—Availability of Services	✓		
Standard V—Assurances of Adequate Capacity and Services	✓		
Standard VI—Coordination and Continuity of Care	✓		
Standard VII—Coverage and Authorization of Services	✓		
Standard VIII—Provider Selection		✓	
Standard IX—Confidentiality		✓	
Standard X—Grievance and Appeal Systems		✓	
Standard XI—Subcontractual Relationships and Delegation		✓	
Standard XII—Practice Guidelines		✓	
Standard XIII—Health Information Systems[1]		✓	
Standard XIV—Quality Assessment and Performance Improvement Program		✓	

[1] The Health Information Systems standard includes an assessment of each MCP's information system.

Technical Methods of Data Collection and Analysis

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DHS and the MCP as they related to the scope of the review. HSAG also followed the guidelines set forth in the CMS *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019[A-5] (Protocol 3) for the following activities:

[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: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 21, 2021.

Pre-review activities included:

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

Site review activities included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's one-day review activities.
- A review of service authorization denial records HSAG requested from the MCP.
- A review of the data systems that the MCP used in its operation such as utilization management, care coordination, and enrollment and disenrollment.
- Interviews conducted with the MCP's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-review activities: HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCP during the period covered by HSAG's review. This scoring methodology is consistent with CMS' Protocol 3.

- ***Met*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, is present.
  - Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- ***Not Met*** indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements *Not Applicable* to the MCP were scored *NA* and were not included in the denominator of the total score.

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

For the member handbook, provider directory, and member rights checklists reviewed, HSAG scored each applicable element within the checklist as either (1) *Yes*, the element was contained within the associated document(s), or (2) *No*, the element was not contained within the document(s). Elements *Not Applicable* to the MCP were scored *NA* and were not included in the denominator of the total score. To obtain a percentage score, HSAG totaled the number of elements that received *Yes* scores, then divided this total by the number of applicable elements.

HSAG conducted file reviews of the MCP's records for service authorization denials to verify that the MCP had put into practice what the MCP had documented in its policy, as well as adhered to timely review of authorization requirements. HSAG selected 10 records of service authorization denials from the full universe of records provided by the MCP. The file reviews were not intended to be a statistically significant representation of all the MCP's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCP staff members. Based on the results of the file reviews, the MCP must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

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

- Documented findings describing the MCP's progress in achieving compliance with State and federal requirements.

- Scores assigned to the MCP's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- The total percentage-of-compliance score calculated for each checklist.
- The overall percentage-of-compliance score calculated across the checklists.
- The total percentage-of-compliance score calculated for each file review.
- The overall percentage-of-compliance score calculated across the file reviews.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

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

Remediation of Deficiencies

The MCPs were required to submit a CAP for all elements that received a *Not Met* score. Additionally, to ensure that timely action is taken to remedy all noted deficiencies through the CY 2021 reviews, the MCPs are required to submit to DHS and HSAG progress reports that provide status updates for each MCP's plans of action. DHS and HSAG review the progress reports to ensure the MCPs are on track to successfully mitigate any gaps in processes and achieve full compliance in each program area not achieving 100 percent compliance.

Description of Data Obtained and Related Time Period

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Narrative and/or data reports across a broad range of performance and content areas.
- MCP-maintained records for service authorization denials.
- MCP's online member handbook and provider directory.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the MCP's key staff members. Table A-8 lists the major data sources HSAG used in determining the MCP's performance in complying with requirements and the time period to which the data applied.

Table A-8—Description of MCP Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the site review	September 1, 2020–February 21, 2021
Information obtained through interviews	May 10–13, 2021
Information obtained from a review of a sample of service authorization denial records for file reviews	Listing of all denials (excluding concurrent reviews) between December 1, 2020–February 21, 2021

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each MCP individually, HSAG used the quantitative results and percentage-of-compliance score calculated for each standard. As any standard or program area not achieving 100 percent compliance required a formal CAP, HSAG determined each MCP's substantial strengths and weaknesses as follows:

- Strength—Any program area that achieved 100 percent compliance.
- Weakness—Any program area that received 80 percent or less compliance.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality and timeliness of, and access to care and services that the MCP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members.

PAHP Readiness Review

Activity Objectives

Effective July 1, 2021, DHS transitioned the administration of children's Medicaid dental benefits (DWP Kids) from an FFS program to a managed care program. DHS requested that HSAG conduct a readiness review of the existing PAHPs in key program areas noted in 42 CFR §438.66(d)(4) and displayed in Table A-9. The objective of the readiness review activity was to assess the PAHPs' capability to support their obligations to DHS under the DWP Kids contract and to ensure appropriate service delivery to the transitioning population. The CY 2021 compliance review activity and readiness review activity occurred simultaneously; therefore, HSAG used the results of the compliance review to supplement findings for the readiness review in overlapping program areas.

Table A-9 also identifies program areas in which DHS maintained responsibility for assessing the PAHPs' readiness, and these program areas were not part of the readiness review performed by HSAG.

Table A-9—Federal Readiness Review Areas

Federal Readiness Review Areas	Responsible Entity	
	HSAG	DHS
Operations/Administration		
Administrative Staffing and Resources	✓	
Delegation and Oversight	✓	
Member and Provider Communications	✓	
Grievance and Appeals	✓	
Member Services and Outreach	✓	
Provider Network Management	✓	
Program Integrity/Compliance		✓
Service Delivery		
Case Management/Care Coordination/Service Planning	✓	
Quality Improvement	✓	
Utilization Review	✓	
Financial Management		
Financial Reporting and Monitoring		✓
Financial Solvency		✓
Systems Management*		
Claims Management and Encounter Data*	✓	✓

* While DHS maintained responsibility for assessing the PAHPs' readiness as it relates to systems management, HSAG's readiness included a high-level assessment of each PAHP's enrollment information, and encounter data and claims management.

Technical Methods of Data Collection and Analysis

Methods for Data Collection

Before beginning the readiness reviews, HSAG developed a data collection tool and questionnaire (i.e., readiness review tool) to document the review. The requirements in the tool were based on applicable federal regulations for conducting a readiness review. In February 2021, HSAG initiated the readiness review activities by notifying the PAHPs of the upcoming readiness review which included a description of the activities and each PAHP's respective readiness review tool. This notification was followed by a technical assistance webinar with the PAHPs to review the activity and expectations and to provide the PAHPs the opportunity to ask any questions.

Data Collection Tools

The readiness review tools contained 10 program areas based on the requirements of 42 CFR §438.66(d)(4). A total of 48 applicable requirements within the 10 program areas were reviewed as part of the readiness review. Certain elements were considered more critical to the successful transition of the Medicaid child FFS population into managed care, such as staffing and resources to manage the increase in membership, ability to notify the new membership of the services available and how to obtain those services, and provider network adequacy. DHS and HSAG designated those elements as "critical," with the expectation that the PAHPs prioritize the functions associated with those elements prior to accepting enrollment and commencing services. The requirements considered critical are denoted (with an asterisk [*]) within each PAHP's readiness review tool.

Readiness Review Activities

To complete the readiness review, HSAG conducted pre-review,[A-6] virtual review, and post-review activities.

Pre-review activities included:

- Developing the PAHPs' respective readiness review tools.
- Preparing and forwarding to the PAHPs a customized overview form with instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- Scheduling the virtual reviews.
- Conducting a readiness review preparation webinar.
- Conducting a desk review of documents. HSAG conducted a desk review of the information obtained from the PAHPs. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the PAHPs' operations, identify areas needing clarification, and begin compiling information before the virtual reviews.
- Developing an agenda for the one-day virtual review.

Virtual review activities included:

- Facilitating an opening conference, with introductions and a review of the agenda and logistics for HSAG's virtual review activities.
- Interviewing PAHP key administrative and program staff members.
- Reviewing each PAHP's data systems used in its operations, such as UM, and enrollment and claims processing.
- Facilitating a closing conference during which HSAG reviewers summarized their preliminary findings.

[A-6] Due to the coronavirus disease 2019 (COVID-19) pandemic, the interview portion of the readiness review was held virtually via Webex.

Post-review activities: HSAG reviewers aggregated findings to produce this readiness review report. In addition, HSAG updated the readiness review tool to create a template for the PAHPs to detail their plans to remedy the deficiencies noted. The readiness review tool contained the findings and recommendations for each requirement found to be *Incomplete* during the readiness review. The PAHPs were required to use the readiness review tool to submit their plans to HSAG and DHS to remediate all elements scored *Incomplete* or *Incomplete—Critical.* DHS maintained ultimate authority for designating critical elements and approving remediation plans submitted in response to the readiness review.

Data Aggregation and Analysis

From a review of documents, observations, and interviews with key staff during the readiness review, HSAG surveyors assigned a score for each requirement within a program area as *Complete*, *Incomplete*, or *Incomplete—Critical*. Subsequently, each program area was assigned an overall completion status of *Complete* or *Incomplete*. All requirements within each program area must have been determined to be *Complete* in order for the overall completion status for the program area to be assigned *Complete*.

HSAG's scoring included the following:

- ***Complete*** indicates full compliance defined as *all* of the following:
  - All documentation was present.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) contained sufficient information to ascertain how the PAHP met this requirement.
  - The documentation included appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
  - Staff members provided responses consistent with the policies and/or processes described in documentation.
- ***Incomplete*** indicates noncompliance defined as *either* of the following:
  - A portion of the documentation was unclear or contained conflicting information that did not address the regulatory requirements.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) did not contain the information needed to ascertain how the PAHP met this requirement.
  - The documentation did not have the appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
  - Staff members had little or no knowledge of processes or issues addressed by the regulatory and/or contractual provisions.
  - For those provisions with multiple components, key components of the provision could be identified and any *Incomplete* findings would result in an overall finding of *Incomplete*, regardless of the findings noted for the remaining components.
- ***Incomplete—Critical*** indicates noncompliance (defined above) and required that the PAHP correct a deficiency prior to the transition of the Medicaid child dental FFS population into managed care.

Remediation Plan

The PAHPs were required to submit a remediation plan to remedy all requirements determined to be *Incomplete* or *Incomplete—Critical*. Further, the PAHPs were required to prioritize action plans to address and remedy the critical items noted in the overall conclusions above. All critical items were required to be successfully remediated prior to the transition effective date of July 1, 2021. The PAHPs were required to submit their remediation plans to HSAG and DHS within five business days after receiving their completed readiness review tools with findings.

The criteria used in evaluating the sufficiency of the remediation plan were:

- The completeness of the remediation plan in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization has or will take.
- The degree to which the planned activities/interventions met the intent of the requirement.
- The appropriateness of the timeline for correcting the deficiency.

The PAHPs were required to resubmit any remediation plans that did not meet the above criteria until approved by DHS.

Description of Data Obtained and Related Time Period

To assess the PAHPs' ability and capacity to perform managed care activities consistent with federal regulations, HSAG obtained information from a wide range of written documents produced by the PAHPs, including, but not limited to, the following:

- Updated policies, procedures, and processes specific to the Medicaid child dental population
- The provider manuals and other communication to providers/subcontractors
- The member handbook and other written informational materials to members
- Narrative and/or data reports across a broad range of performance and content areas
- Organizational staffing and hiring plans
- PAHP websites
- Network data and information

The documentation reviewed was in effect on or before the go-live date of the transition, July 1, 2021. HSAG also obtained additional information for the readiness review through interactive discussions and interviews with PAHP key staff members and system demonstrations provided by PAHP staff members.

Network Adequacy Validation

Activity Objectives

The goal of the network adequacy projects was to ensure the MCPs' members have adequate access to the health care services. For the MCOs, HSAG assessed the utilization of telehealth and members' access to telehealth. For the PAHPs, HSAG assessed the member service disruption after the transition from the FFS program to the managed care program.

Technical Methods of Data Collection and Analysis

MCOs

HSAG obtained Medicaid member demographic information, Medicaid member enrollment information, and medical encounter data from DHS. The list below is a high-level summary of the data provided:

- Member demographic data included key data elements such as the unique member identifier, sex, age, race, and residential address as of December 31, 2020.
- Member eligibility and enrollment files included the start and end dates for MCO enrollment for CY 2020.
- Encounter data for CY 2019 and CY 2020 for medical services with service dates between January 1, 2019, and December 31, 2020.

HSAG cleaned, processed, and defined the unique set of telehealth encounters and identified study-eligible members for inclusion in the analysis. Telehealth encounters were limited to services provided during CY 2020 and were identified using the DHS-provided logic presented in Table A-10.

Table A-10—Telehealth Reporting Logic

AGP Reported Logic	ITC Reported Logic
Place of Service (POS) Code: 02	Place of Service (POS) Code: 02

Members were limited to those enrolled at any point during CY 2020. Members were identified as having a chronic condition based on the HEDIS performance measure, *Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions*. HSAG used the chronic conditions defined by the performance measure plus additional high-risk chronic conditions with value sets defined by HSAG. The chronic conditions, the value sets, and their source are listed in Table A-11. Any member who had an encounter with a diagnosis that included any of the listed chronic conditions during CY 2019 or CY 2020 was defined as having a chronic condition.

Table A-11—Chronic Conditions

Chronic Condition	Value Set	Source
Acute myocardial infarction (MI)	MI Value Set	HEDIS

Chronic Condition	Value Set	Source
Alzheimer's disease and related disorders	Dementia Value Set Frontotemporal Dementia Value Set	HEDIS
Atrial fibrillation	Atrial Fibrillation Value Set	HEDIS
Autism	Other Psychotic and Developmental Disorders Value Set	HSAG
Bipolar disorder	Bipolar Disorder Value Set Other Bipolar Disorder Value Set	HSAG
Chronic kidney disease	Chronic Kidney Disease Value Set	HEDIS
Chronic obstructive pulmonary disease (COPD) and asthma	COPD Diagnosis Value Set Asthma Diagnosis Value Set Unspecified Bronchitis Value Set	HEDIS
Depression	Major Depression Value Set Dysthymic Disorder Value Set	HEDIS
Diabetes	Diabetes Value Set	HSAG
Heart failure	Chronic Heart Failure Value Set Heart Failure Diagnosis Value Set	HEDIS
Major depressive disorder	Major Depression or Dysthymia Value Set	HSAG
Schizophrenia	Schizophrenia Value Set	HSAG
Stroke and transient ischemic attack	Stroke Value Set (exclude Stroke Exclusion and Other Stroke Exclusions Value Sets)	HEDIS

Due to the impact on Medicaid enrollment during the coronavirus disease 2019 (COVID-19) public health emergency, HSAG calculated weighted and unweighted values for all proportions. Unweighted values count each member as being enrolled, regardless of how long the member was enrolled with the MCO. Weighted values were adjusted for the length of time a member was enrolled in Medicaid, since the COVID-19 public health emergency unpredictably increased the number of people who qualified for Medicaid. For example, if a member was enrolled for six out of 12 months, in the weighted analysis, the member would be weighted at one-half.

PAHPs

Once the data files were received and processed for inclusion in the analysis, HSAG conducted the following analyses:

- *Comparison between providers historically used by members through FFS and providers contracted with the new PAHP networks:* This comparison used encounter data to identify FFS providers previously used by members but not captured in the PAHPs' provider networks. The comparison identified specific provider specialties no longer accessible to members in their PAHPs' provider

networks. It also quantified the number of providers in the FFS network that are not available in the PAHPs' networks.

- *Calculation of the percentage of members in the new PAHP networks with access to general dentists within the access standards:* HSAG conducted a time/distance analysis assessing the percentage of DWP Kids members with access to a general dentist within the time/distance standards under the PAHP networks as shown in Table A-12.

Table A-12—Dental Provider Categories and Access Standards

Provider Specialty	Criteria for Members	Access Standard
General Dental Providers		
General Dentist	All DWP Kids members that were transitioned to a PAHP on July 1, 2021	30 minutes or 30 miles for members in urban areas AND 60 minutes or 60 miles for members in rural areas[A-7]

- *Calculation of the change in average time and distance to reach the nearest provider for members whose providers are no longer in their provider network:* HSAG conducted a time/distance analysis comparing the time/distance to the nearest FFS dental provider to the members' time/distance to the nearest provider of the same specialty in the PAHP's provider network.
- *Comparison of the number of providers accepting new patients in the FFS network and the PAHP's provider networks:* HSAG assessed the number of providers accepting new patients in the FFS DWP Kids provider network and the PAHPs' provider networks to determine if the number of providers accepting new patients available to the DWP Kids members will change substantially after the transition to managed care.

Description of Data Obtained and Related Time Period

MCOs

HSAG obtained member eligibility and enrollment files included the start and end dates for MCO enrollment for CY 2020 and member demographic data which included key data elements such as the unique member identifier, sex, age, race, and residential address. HSAG also obtained encounter data for CY 2019 and CY 2020 for medical services with service dates between January 1, 2019, and December 31, 2020.

[A-7] Rural areas are defined as areas not designated as Metropolitan Statistical Areas (MSAs). Urban areas are defined as MSAs.

PAHPs

To complete the disruption analysis, HSAG obtained Medicaid member demographic information and corresponding dental provider network files from DHS and the PAHP, which included:

- The member demographic data containing key data elements such as unique member identifier, gender, age, and residential address as of July 1, 2021.
- The member eligibility and enrollment files containing the start and end dates for the PAHP enrollment.
- The dental provider data containing the FFS provider network as of June 30, 2021 and the providers actively enrolled in a PAHP as of July 1, 2021. DHS provided the data for the dentists in the IME data and the PAHPs provided the data for the dentists contracted to provide services to the DWP Kids member (i.e., actively enrolled with the PAHP) as of July 1, 2021. Some of the key data elements included were unique provider identifier, enrollment status with the PAHPs, provider type, provider specialty, and service address as of July 1, 2021.
- The encounter data for CY 2019 and CY 2020 for dental services with service dates between January 1, 2019 and December 31, 2020. HSAG used the encounter data to identify the network of dentists who provided services to the DWP Kids members during CY 2019 and CY 2020. This network was compared the to the PAHPs network to assess access to care under the new PAHPs' network compared to the original FFS network.

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 the results of telehealth utilization in four dimensions, including use of telehealth services by member demographics, member geography, and members with chronic conditions compared to members without chronic conditions. HSAG further analyzed whether DWP Kids members had adequate access to dental provider services after the transition of dental services from the FFS program to the managed care program. HSAG used the NAV activity results to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of, timeliness of, and access to care and services furnished by the MCP's Medicaid managed care members.

Encounter Data Validation

Activity Objectives

HSAG's approach to conducting EDV studies is tailored to address the specific needs of its clients by customizing elements outlined in the CMS External Quality Review (EQR) Protocol. In alignment with the CMS EQR Protocol 5, *Validation of Encounter Data Reported by the Medicaid and CHIP Managed*

Care Plan[A-8], in general, the following core evaluation steps describe HSAG's approach to conducting the EDV activity:

- Information Systems (IS) Review— assessment of the State's and/or MCOs' information systems and processes
- Administrative profile—analysis of the State's electronic encounter data completeness, accuracy, and timeliness
- Comparative analysis—analysis of the State's electronic encounter data completeness and accuracy through a comparative analysis between the State's electronic encounter data and the data extracted from the MCOs' data systems
- Technical assistance—follow-up assistance provided to the MCOs that perform poorly in the comparative analysis
- MRR—analysis of the State's electronic encounter data completeness and accuracy through a comparison between the State's electronic encounter data and the information documented in the corresponding members' medical records.

MCOs

During CY 2020 and 2021, HSAG conducted the EDV study for the two MCOs. For Amerigroup Iowa, HSAG had conducted the core EDV activities listed above, except for MRR. Because 2019 was the first year Iowa Total Care submitted encounter data to DHS, HSAG conducted an IS review with Iowa Total Care in CY 2019. As such, for CY 2020 and CY 2021, HSAG conducted the core evaluation activities according to Table A-13 for each of the respective MCOs.

Table A-13—Core Evaluation Activities for CY 2020 and CY 2021 for each MCO

Calendar Year	MCO	Core Activity	Study Review Period*
CY 2020	AGP	MRR	January 1, 2019—December 2019
	ITC	Administrative Profile Analysis	July 1, 2019—December 31, 2019
CY 2021	AGP	Comparative Analysis/Technical Assistance	January 1, 2019—June 30, 2020
	ITC		July 1, 2019—June 30, 2020

* Study review period refers to the encounter dates of service to be evaluated.

The administrative profile analysis of the State's encounter data is essential to gauging the general completeness, accuracy, and timeliness of encounter data. The degree of the MCO's data file completeness and accuracy provide insight into the quality of DHS' overall encounter system and represents the basis for establishing confidence in reporting and rate setting activities.

[A-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 5 Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*. Protocol 5. October 2019.

The goal of the comparative analysis was to evaluate the extent to which encounters submitted to DHS by the MCOs are complete and accurate, based on corresponding information stored in the MCOs' data systems.

Medical and clinical records are considered the "goal standard" for documenting Medicaid members' access to quality of healthcare services. As such, the goal of the MRR is to assess DHS' data quality through investigating the completeness and accuracy of DHS' encounters compared to the information documented in the corresponding medical records for Medicaid members.

PAHPs

For the PAHPs, HSAG conducted the core EDV activities noted previously, except for the administrative profile. As such, during CY 2021, HSAG conducted an administrative profile, or analysis of DHS' electronic dental encounter data. The goal of the study was to examine the accuracy, completeness, and timeliness of DHS' encounter data.

Technical Methods of Data Collection and Analysis

MCOs

Administrative Profile Analysis

In conducting this component of the EDV study, HSAG used various data sources including encounter data, member demographic/enrollment data, and provider data. HSAG submitted a data submission requirements document to notify DHS of the required data needed. The data submission requirements document was developed based on the study objectives and data elements to be evaluated in the study. It included a brief description of the study, the review period, required data elements, and information regarding the submission of the requested files.

To assist DHS in preparing the requested data files, HSAG provided a technical assistance session through conference call(s), when necessary. During the technical assistance session, HSAG reviewed the data submission requirements to ensure that all questions related to data preparation and extraction were addressed. Following completion of the technical assistance session, HSAG updated and forwarded a final version of the data submission requirements document to DHS for review and approval.

As presented in Table A-13, HSAG examined the accuracy, completeness, and timeliness of DHS' encounters submitted by Iowa Total Care with dates of service from July 1, 2019 through December 31, 2019. HSAG proposed evaluating the following metrics:

Metrics for Encounter Data Completeness

- Monthly encounter record counts by MMIS month (i.e., the month when encounters were processed by MMIS).

- Monthly encounter volume by service month (i.e., the month when services occur). For this metric, encounter volume was evaluated using visit-level variables (i.e., member, date of service, and provider) to avoid double counting.
- Monthly encounter volume per 1,000 member months (MM) by service month to account for variation on the member counts from month to month.
- Monthly paid amount per member per month (PMPM) by service month.

Metrics for Encounter Data Timeliness

- Claims lag triangle to illustrate the percentage of encounters accepted into DHS' data system within two months, three months, ..., and such from the service month.
- Percentage of encounters received by MMIS within 30 days, 60 days, 90 days, …, and such from the MCO payment date.

Metrics for Field-Level Encounter Data Completeness and Accuracy

- Percent present and percent with valid values for selected key data elements listed in Table A-14.

Table A-14—Key Encounter Data Elements

Key Data Elements	Professional	Institutional	Pharmacy	Criteria for Validity
Member ID	√	√	√	• In member file supplied by DHS • Eligible for Medicaid on the date of service • Enrolled in a specific MCO on the date of service
Detail Service From Date	√	√	√	• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date	√	√		• Detail Service From Date ≤ Detail Service To Date • Detail Service To Date ≤ Paid Date
Paid Date	√	√	√	• Paid Date ≥ Detail Service From Date • Paid Date ≥ Detail Service To Date
Billing Provider Number	√	√	√	• In provider file supplied by DHS
Rendering Provider Number	√			• In provider file supplied by DHS
Attending Provider Number		√		• In provider file supplied by DHS
Prescribing Provider Number			√	• In provider file supplied by DHS

Key Data Elements	Professional	Institutional	Pharmacy	Criteria for Validity
Primary Diagnosis Code	√	√		• In national ICD-10-CM diagnosis code sets
Secondary Diagnosis Code(s)	√	√		• In national ICD-10-CM diagnosis code sets
CPT/HCPCS Code(s)	√	√		• In national CPT and HCPCS diagnosis code sets
Surgical Procedure Code(s)		√		• In national ICD-10-CM surgical procedure code sets
Revenue Code		√		• In national revenue code sets
DRG Code		√		• In national DRG code sets
NDC	√	√	√	• In national NDC code sets

HSAG stratified Iowa Total Care's results by the appropriate encounter types such as HCFA-1500, Medicare Part B crossover, waiver, inpatient, inpatient crossover, long-term care, outpatient, outpatient crossover, and pharmacy based on the following *Claim Type* field values in DHS' data warehouse:

- Professional:
  - HCFA-1500 (i.e., *Claim Type* = M)
  - Medicare Part B crossover (i.e., *Claim Type* = B)
  - Waiver (i.e., *Claim Type* = W)
- Institutional:
  - Inpatient (i.e., *Claim Type* = I)
  - Inpatient crossover (i.e., *Claim Type* = X)
  - Long-term care (i.e., *Claim Type* = N)
  - Outpatient (i.e., *Claim Type* = O)
  - Outpatient crossover (i.e., *Claim Type* = V)
- Pharmacy (i.e., *Claim Type* = P)

Comparative Analysis

As outlined in Table A-13, both Amerigroup Iowa and Iowa Total Care were included in this component of the EDV activity for CY 2021. In this activity, HSAG developed a data requirements document requesting claims/encounter data from both DHS and the MCOs. A follow-up technical assistance session occurred approximately one week after distributing the data requirements documents, thereby allowing the MCOs time to review and prepare their questions for the session. Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure data were sufficient to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Data were extracted based on the data requirements document.
- Percentage present—Required data fields are present on the file and have values in those fields.
- Percentage of valid values—The values are the expected values; e.g., valid ICD-10 codes in the diagnosis field.
- Evaluation of matching claim numbers—The percentage of claim numbers that matched between the data extracted from DHS' data warehouse and the MCOs' data submitted to HSAG.

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

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

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

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

Second, based on the number of records present in both data sources, HSAG examined completeness and accuracy for key data elements listed in Table A-15. The analyses focused on an element-level comparison for each element.

Table A-15—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Member ID	√	√	√
Header Service From Date	√	√	√
Header Service To Date	√	√	
Admission Date		√	
Billing Provider NPI	√	√	√
Rendering Provider NPI	√		
Attending Provider NPI		√	
Prescribing Provider NPI			√
Referring Provider NPI	√	√	
Primary Diagnosis Code	√	√	
Secondary Diagnosis Code	√	√	
Procedure Code	√	√	
Procedure Code Modifier	√	√	

Key Data Elements	Professional	Institutional	Pharmacy
Units of Service	√	√	
Primary Surgical Procedure Code		√	
Secondary Surgical Procedure Code		√	
NDC	√	√	√
Drug Quantity			√
Revenue Code		√	
DRG Code		√	
Header Paid Amount		√	√
Detail Paid Amount	√	√	
Dispensing Fee			√

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

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

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

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

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

Medical Record Review

As outlined in Table A-13, only Amerigroup Iowa was included in the medical record review component of the CY 2020 EDV study. As outlined in the CMS protocol, medical record review is a

complex and resource-intensive process. Medical and clinical records are considered the "gold standard" for documenting access and the quality of healthcare services.

The MRR activity evaluated encounter data completeness and accuracy through a review of medical records for physician services rendered between January 1, 2019 and December 31, 2019. This component of the study answered the following question:

Are the data elements in Table A-16 *found on the professional encounters complete and accurate when compared to information contained within the medical records?*

Table A-16—Key Data Elements for MRR

Key Data Element	
Date of Service	Diagnosis Code
Procedure Code	Procedure Code Modifier

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

- Identified the eligible population and generated samples from data extracted from the DHS data warehouse.
- Assisted Amerigroup Iowa to procure medical records from providers, as appropriate.
- Reviewed medical records against DHS' encounter data.
- Calculated study indicators based on the reviewed/abstracted data.
- Drafted report based on study results.

Study Population

To be eligible for the MRR, a member had to be continuously enrolled in the same MCO during the study period (i.e., between January 1, 2019 and December 31, 2019), and had to have had at least one professional visit during the study period. In addition, members with Medicare or other insurance coverages were excluded from the eligible population since DHS may not have all services they received that were covered by either Medicare and/or other insurances (but were documented in the members' medical records). After reviewing the encounter data extracted from the DHS data warehouse, HSAG discussed with DHS how to identify "professional visits" from the encounter data, as needed.

Sampling Strategy

HSAG used a two-stage sampling technique to select samples based on the member enrollment and encounter data extracted from the DHS data warehouse. HSAG first identified all members who met the study population eligibility criteria, and then used random sampling to select 411 members[A-9] from the eligible population for Amerigroup. Then, for each selected sampled member, HSAG used the

[A-9] The sample size of 411 is based on a 95 percent confidence level and a margin of error of 5 percent.

SURVEYSELECT procedure in SAS®,[A-10] to randomly select one professional visit[A-11] that occurred in the study period (i.e., between January 1, 2019 and December 31, 2019). Additionally, to evaluate whether any dates of service were omitted from the DHS data warehouse, HSAG reviewed a second date of service rendered by the same provider during the review period. The providers selected the second date of service, which was closest to the sampled date of service, from the medical records for each sampled member. If a sampled member had no second visit with the same provider during the review period, HSAG evaluated only one date of service for that member. As such, for Amerigroup Iowa, the final number of visits reviewed was between 411 and 822.

Medical Record Procurement

Upon receiving the final sample list from HSAG, Amerigroup Iowa was responsible for procuring the sampled members' medical records from its contracted providers for services that occurred during the study period. In addition, Amerigroup was responsible for submitting the documentation to HSAG. To improve the procurement rate, HSAG conducted a one-hour technical assistance session with Amerigroup to review the EDV project and the procurement protocols after distributing the sample list. Amerigroup Iowa was instructed to submit medical records electronically via a Secure Access File Exchange (SAFE) site to ensure the protection of personal health information. During the procurement process, HSAG worked with Amerigroup Iowa to answer questions and monitor the number of medical records submitted. For example, HSAG provided an initial submission update when 40 percent of the records were expected to be submitted and a final submission status update following completion of the procurement period.

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

Review of Medical Records

HSAG's experienced medical record reviewers were responsible for abstracting the medical records. In order to successfully complete the study, the project lead worked with the medical record review team (MRT) beginning with the methodology phase. The MRT was involved with the tool design phase, as well as the tool testing to ensure that the abstracted data are complete and accurate. Based on the study methodology, clinical guidelines, and the tool design/testing results, the MRT drafted an abstraction instruction document specific to the study for training purposes. Concurrent with record procurement activities, the MRT trained the medical record reviewers on the specific study protocols and conducted

[A-10] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

[A-11] To ensure that the MRR includes all services provided on the same date of service, encounters with the same date of service and same rendering provider were consolidated into one visit for sampling purposes.

interrater reliability and rater-to-standard testing. All medical record reviewers had to achieve a 95 percent accuracy rate for the training/testing cases before they can review medical records and collect data for the study.

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

The validation of encounter data incorporated a unique two-way approach through which encounters were chosen from both the electronic encounter data and from medical records and were subsequently compared with one another. Claims/encounters selected from encounter data received from DHS were compared against the medical record; and visit information from the medical record were compared against encounter data received from DHS. This process allowed the study to identify services documented in the members' medical records and that are missing from the DHS system (i.e., *encounter data omission*), as well as identify encounters present in the DHS data warehouse but not documented in the members' medical records (i.e., *medical record omission*). For services in both data sources, an analysis of coding accuracy was completed. Information that existed in both data sources but whose values did not match were considered discrepant.

Study Indicators

Once the MRR was completed, HSAG analysts exported information collected from the electronic tool, reviewed the data, and conducted the analysis. HSAG used four study indicators to report the MRR results:

- *Medical record omission rate*: the percentage of dates of service identified in the electronic encounter data that were not found in the members' medical records. HSAG also calculated this rate for the other key data elements in Table A-16.
- *Encounter data omission rate*: the percentage of dates of service from members' medical records that were not found in the electronic encounter data. HSAG also calculated this rate for the other key data elements in Table A-16.
- *Accuracy rate of coding*: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that were correctly coded based on the members' medical records.
- *Overall accuracy rate:* the percentage of dates of service with all data elements coded correctly among all the validated dates of service from the electronic encounter data.

PAHPs

HSAG used several data sources including dental encounter data, member demographic and enrollment data, and provider data. HSAG submitted a data submission requirements document to notify DHS of the required data needed. The data submission requirements document was developed based on the study objectives and data elements to be evaluated in the study. It included a brief description of the study, the review period, required data elements, and information regarding the submission of the requested files.

To assist DHS in preparing the requested data files, HSAG provided a technical assistance session through conference call(s), when necessary. During the technical assistance session, HSAG reviewed the data submission requirements to ensure that all questions related to data preparation and extraction were addressed. Following completion of the technical assistance session, HSAG updated and forwarded a final version of the data submission requirements document to DHS for review and approval.

To examine the accuracy, completeness, and timeliness of DHS' dental encounter data, HSAG assessed the dental encounter data with service dates from July 1, 2019, to June 30, 2020.

Metrics for Encounter Data Completeness

- Monthly encounter record counts by Medicaid Management Information System (MMIS) month (i.e., the month when encounters were received by MMIS).
- Monthly encounter volume by service month (i.e., the month when services occur). For this metric, encounter volume was evaluated using visit-level variables (i.e., member, date of service, and provider) to avoid double counting.
- Monthly encounter volume per 1,000 member months (MM) by service month to account for variation on the member counts from month to month.
- Monthly paid amount per member per month (PMPM) by service month.

Metrics for Encounter Data Timeliness

- Claims lag triangle to illustrate the percentage of encounters accepted into DHS' data system within one month, two months, three months, …, and such from the service month (i.e., lag days between service date and MMIS date).
- Percentage of encounters received by MMIS within 30 days, 60 days, 90 days, …, and such from the payment date (i.e., lag days between PAHP payment date and MMIS date).

Metrics for Field-Level Encounter Data Completeness and Accuracy

- Percent present and percent with valid values for selected key data elements.

Description of Data Obtained and Related Time Period

MCOs

Administrative Profile Analysis

HSAG used various data sources including encounter data, member demographic/enrollment data, and provider data. HSAG examined encounters submitted by Total Care with dates of service from July 1, 2019 through December 31, 2019. The enrollment data included a listing of enrollment spans for all Medicaid members that were actively enrolled in an MCO during the study period. The provider data contained all billing and rendering providers that had a record in the encounter data.

Comparative Analysis

For comparative analysis, HSAG used encounter data from DHS and the MCOs. For Amerigroup Iowa, HSAG assessed DHS' and Amerigroup Iowa's encounters with dates of service from January 1, 2019 through June 30, 2020. For Iowa Total Care, since it began submitting encounters to DHS on July 1, 2019, to evaluate the accuracy and completeness of the submitted encounters, the CY 2021 study assessed DHS' and Iowa Total Care's encounters with dates of service from July 1, 2021 through June 30, 2020.

For both Amerigroup Iowa and Iowa Total Care, both paid and denied encounters were included in the analysis. To ensure that the extracted data from both sources represented the same universe of encounters, the data targeted professional, institutional, and pharmacy encounters submitted to DHS on or before November 30, 2020. This anchor date allowed sufficient time for the encounters to be submitted, processed, and available for evaluation in the DHS data warehouse.

Medical Record Review

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

PAHPs

HSAG used various data sources including dental encounter data, member demographic/enrollment data, and provider data. HSAG examined encounters submitted by the PAHPs with dates of service from July 1, 2019 through June 30, 2020. The enrollment data included a listing of enrollment spans for all Medicaid members that were actively enrolled in a PAHP during the study period. The provider data contained all billing and rendering providers that had a record in the encounter data.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of each MCP's encounter data submissions to DHS, 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 DHS had not yet established standards for results from these activities, to identify strengths and weaknesses, HSAG assessed the results based on the prior year's results, when available, and HSAG's experience in working with other states in assessing the completeness, accuracy, and timeliness of MCPs' encounter data submissions to the State. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality and timeliness of encounter data submitted to DHS.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

This activity assesses members' experience with an MCO and its providers, and the quality of care they receive. The goal of the CAHPS Health Plan Surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

Two populations were surveyed for the MCOs: adult Medicaid and child Medicaid. Center for the Study of Services (CSS) and SPH Analytics, NCQA-certified vendors, administered the 2021 CAHPS surveys for Amerigroup Iowa and Iowa Total Care, respectively.[A-12]

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 Iowa'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 Iowa used a mixed-mode methodology for data collection. Respondents were given the option of completing the survey in Spanish. Iowa Total Care used a mixed-mode methodology for data collection. 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. 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

[A-12] ITC's CAHPS data was not submitted to NCQA, while AGP's CAHPS data was submitted to NCQA.

to address different aspects of care (e.g., getting needed care and how well doctors communicate). The CCC composite measures/items evaluated the experience of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation.

Top-Box Score Calculations

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response or top-box score).

For each of the five composite measures and CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive or top-box response for the composite measures and CCC composites/items was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite measures and CCC composite measures/items. For the Effectiveness of Care measures, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year results.[A-13] When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as NA.

NCQA National Average Comparisons

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

MCO Comparisons

HSAG compared each MCO's and the MCO program's (i.e., Amerigroup Iowa and Iowa Total Care combined) results to the 2020 NCQA national averages to determine if the results were statistically significantly different. Arrows in the tables note statistically significant differences. A green upward arrow (↑) indicates a top-box score was statistically significantly higher than the 2020 NCQA national average. Conversely, a red downward arrow (↓) indicates a top-box score was statistically significantly lower than the 2020 NCQA national average. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as NA.

[A-13] ITC only has one year of CAHPS data available; therefore, the scores were calculated using one year's of data, which deviates from NCQA's methodology.

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, 2020, and child members included as eligible for the survey were 17 years of age or younger as of December 31, 20120 Adult members and parents or caretakers of child members completed the surveys from February to May 2021.

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 compared each MCO's and the MCO program's (i.e., Amerigroup Iowa and Iowa Total Care combined) 2021 survey results to determine if a substantial increase or decrease was denoted by a change of 5 percentage points higher or lower than the 2020 NCQA national averages.

Quality Rating

Activity Objectives

On November 8, 2018, CMS published the Medicaid and CHIP Managed Care Proposed Rule (CMS-2408-P) in the Federal Register. As per 42 CFR §438.334, each state contracting with an MCO to provide services to Medicaid beneficiaries must adopt and implement a quality rating system (QRS). Although the final technical specifications for the QRS have not been released, Medicaid agencies that already have a QRS in place will have an opportunity to use their current QRS to meet CMS requirements. CMS will require states wanting to use an alternative QRS to submit their methodology, including the list of performance measures included in the QRS to CMS.

The scorecard is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection and Analysis

MCO performance was evaluated in six separate reporting categories, identified as important to consumers.[A-14] 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:

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.

[A-14] National Committee for Quality Assurance. "Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports for Consumers." October 1998.

Women's Health: This category consists of HEDIS measures related to screenings for women and maternal health.

Living With Illness: This category consists of HEDIS measures related to diabetes, and cardiovascular and respiratory conditions.

Behavioral Health: This category consists of HEDIS measures related to follow-up care for behavioral health, as well as appropriate care for adults and children on antipsychotics.

Medication Management: This category consists of HEDIS measures related to antibiotic stewardship; and medication management for opioid use and behavioral health conditions.

HSAG computed six reporting category summary scores for the MCO. HSAG compared each measure to national benchmarks and assigned star ratings for each measure. HSAG used the following methodology to assign a star rating for each individual measure:

Table A-17—Measure Rate Star Rating Descriptions

Rating	MCO Measure Rate Performance Compared to National Benchmarks
★★★★★	The MCO's measure rate was at or above the national Medicaid 90th percentile
★★★★	The MCO's measure rate was between the national Medicaid 75th and 89th percentiles
★★★	The MCO's measure rate was between the national Medicaid 50th and 74th percentiles
★★	The MCO's measure rate was between the national Medicaid 25th and 49th percentiles
★	The MCO's measure rate was below the national Medicaid 25th percentile

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-18—MCO Scorecard Performance Ratings

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

Description of Data Obtained and Related Time Period

HSAG analyzed MY 2020 HEDIS results, including MY 2020 CAHPS data from two MCOs: Amerigroup Iowa and Iowa Total Care for presentation in the 2021 Iowa Health Link MCO Scorecard.