Quality Strategy 2021 Evaluation

May 2024

Iowa Medicaid Quality Committee

Contents

Quality Strategy 2021 Evaluation 4
Introduction 4
Managed Care plans (MCP) 4
Methodology 5
Quality Goals 5
Managed Care Organization Goals 5
Dental PAHP Goals 7
Quality Goals Measure Baseline and Trends 9
Managed Care Organization Goals 9
Dental PAHP Goals 28
Quality Strategy Alignment 28
Iowa Medicaid Strategic Plan October 2022 28
Managed Care Plan Pay for Performance 29
Quality Assessment and Performance Improvement (QAPI) Program 30
CMS Required PIPs 30
Network Adequacy 31
Intermediate Sanctions 32
CMS Core Measures Review 33
Directed Payments 34
LTSS Quality Measures 35
HSAG Recommendations 39
EQRO Technical Report April 2023 39
EQRO Technical Report April 2024 39
CMS Feedback to Quality Strategy 2021 (MCO) 40
Managed Care and Goals, Objectives, and Overview 40
Quality and Appropriateness of Care 40
Monitoring and Compliance 41
External Quality Review (EQR) Arrangements 41
CMS Feedback to Quality Strategy 2023 (PHAP) 41
Quality Strategy Review and Submission Elements 41
Quality Measurement and Improvement 43
Here's What We Found 44
Goals 44
MCO 44
Current Medicaid Projects 47
Another Headline **Error! Bookmark not defined.**
Here's some bullet points below **Error! Bookmark not defined.**

Quality Strategy 2021 Evaluation

Introduction

Iowa Health and Human Services Quality Strategy Evaluation for Iowa Medicaid's Quality Strategy 2021 has been evaluated in accordance with 42 CFR §438.340(c)(2). Following the CMS guidance provided in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit published in June 2021, this Evaluation:

1. Describes the methodology used in the evaluation.
2. Lists the quality goals and the quality measures associated with each goal.
3. Provides baseline and subsequent year data for each year.
4. Indicates where improvements have been made, and where opportunities for improvement remain and barriers to success.
5. Identifies areas where improvement goals have not been met, or new goals to add to a future Quality Strategy.
6. Assesses the current Quality Strategy to ensure measures are consistent and aligned across goals, objectives, and programs.
7. Summarizes performance on the CMS Adult and Child Core Measure Sets as well as Health Home.
8. Summarizes Directed Payment alignment.
9. Summarizes HSAG recommendations.

MANAGED CARE PLANS (MCP)

Iowa has three Managed Care Organizations (MCOs), two Pre-Paid Ambulatory Health Plans (PAHPs), and three Program of All-Inclusive Care for the Elderly (PACE) Organizations. All MCOs and PAHPs are statewide, PACE is in three regions.

Plans	Type	Services	Abbreviation	Populations Served
Amerigroup/ Wellpoint	MCO	Behavioral and Physical	AGP/WLP	All members are eligible including CHIP
Iowa Total Care	MCO	Behavioral and Physical	ITC	All members are eligible including CHIP
Molina Healthcare	MCO	Behavioral and Physical	MOL	All members are eligible including CHIP
Delta Dental	PAHP	Dental	DDIA	• Dental Wellness Plan Adults • Dental Wellness Plan Kids • Hawki
MCNA	PAHP	Dental	MCNA	• Dental Wellness Plan Adults • Dental Wellness Plan Kids • Hawki
PACE – Immanuel Pathways Central Iowa	MCO	MLTC	IPCI	• Members 55+

PACE – Immanuel Pathways Southwest Iowa	MCO	MLTC	IPSWI	• Members 55+
PACE - Siouxland	MCO	MLTC	SLP	• Members 55+

Methodology

HHS evaluates and updates the Medicaid Quality Strategy as needed, but no less than once every three years, as required by managed care regulations at 42CFR 438.340(c) and 457.124.
A "significant change" to the Medicaid Quality Strategy is defined as any change that is made which requires the addition or removal of entire processes or measures from the document. The HHS Medicaid Quality Committee will review and approve or deny any updates or changes to the Quality Strategy when quality indicators suggest that new or different approaches must be implemented to improve the quality of care of enrollees.
The following outlines the evaluation process:

1. Iowa Medicaid Quality Committee conducts a formal evaluation of the effectiveness of the quality strategy.
   - Indicates where improvements have been made, and where opportunities for improvement remain and barriers to success.
   - Identifies areas where improvement goals have not been met, or new goals to add to a future Quality Strategy.
   - Assesses the current Quality Strategy to ensure measures are consistent and aligned across goals, objectives, and programs.
   - Summarizes performance on the CMS Adult and Child Core Measure Sets as well as Health Home.
   - Summarizes Directed Payment alignment.
   - Summarizes HSAG recommendations.
2. Iowa Medicaid Quality Committee presents findings to Medical Assistance Advisory Council (MAAC).
3. The results of the Quality Committee's evaluation will be documented and posted on HHS's website within 60 days of its completion.

Quality Goals

Managed Care Plan Goals are created based on a strategic focus that aligns with the Medicaid Strategic Plan and CMS Quality Strategy. Quality Goals for Managed Care Organizations are not SMART goals creating barriers to measuring of goals have been met. This section is high level view of the Managed Care Organization and PAHP strategic focus, goals, and measures.

MANAGED CARE ORGANIZATION GOALS

Strategic Focus	Quality Goal	Measure
Behavioral Health	Measuring FUH/FUM for all member stratified by LTSS and Health Home	FUH and FUM
Access to Care	• Increase covered lives in a VBP arrangement to 40% • Improve Network Adequacy • Improve Timeliness of Postpartum Care: Primary Cesarean Rate	% of members in a VBP Network Adequacy Project with EQRO Primary Cesarean Rate (U of I Directed Payment)

	Increase Access to Primary and Secondary Care (GEMT, Primary Care)	GEMT Review of transport types Primary Care Measures (U if I Directed Payments)
Program Administration	Meet measure thresholds for TCR and ED.	Timely Claims Reprocessing and Encounter Data
Decrease Cost of Care	Reducing the rate of potentially Preventable readmissions and non-emergent ED visits	All Cause Readmission (Core Measure) Ambulatory Care ED Visits Total (CH)
Improving Coordinated Care	• 70% of HRAs will be completed withing 90 days of enrollment and annually. • Improve Postpartum visit rate. • Improve 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	HRA completion rates Postpartum visit rates Gestational glucose screening rates LOC and Needs based eligibility assessment rates. Initial and annual service plan review and updates completion.
Continuity of Care	• 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. • Monitoring transition and discharge planning for Long-Term Services and Supports (LTSS) members	Specific measures were not identified for this goal. IPES Member Survey Ride Alongs
Health Equity	• Identify Health disparities or inequities and target those areas for improvements. • Monitor the implementation and progress of the Health Equity Plans	Behavioral Health Substance Use Disorder Postpartum Asthma Diabetes Community Integration
Voice of the Customer	• Annually review the CAHPS results and make recommendations for improvement.	MCO CAHPs Surveys

	Quality Goal	Measure
	• Quarterly review the HCBS IPES results and make recommendations for improvement. • Quarterly review the appeals and grievance reports and make recommendations for improvement.	IPES Surveys Quarterly Appeals and Grievance

DENTAL PAHP GOALS

Strategic Focus	Quality Goal	Measure
Improve Network Adequacy and Availability of Services	• Increase the number of general dentists who actively see patients in the dental program. • Increase the number of specialty dentists who actively see patients in the dental program. • Increase the number of members who access any dental care in the year.	• Number of unique members with 6+ month coverage in fiscal year accessing care • Number of credentialed network providers (excluding teaching facilities) rendering any dental services to at least 3 distinct members within the fiscal year • Number of credentialed network providers specialty providers (excluding teaching facilities) rendering any dental services to at least 3 distinct members within the fiscal year • Number of enrollees who make appointments within the maximum wait time for urgent and non-urgent care.
Increase Recall and Prevention Services	• Members Who Received Preventive Dental Care • Continued Preventative Utilization • Members Who Received Two Topical Fluoride Applications • Members Who Received a Dental Sealant • Members Who Received a Dental Sealant on all Four Molars by Age 10 • Increase the percentage of enrolled adults aged 30 years and older with a history of periodontitis who receive maintenance care.	• Number of unique members with 6+ month coverage accessing any care and receiving a preventive exam • Unique members with 6+ months accessing an oral eval and 6-12 months prior accessed an oral eval within 12 months of the consecutive coverage period. • Unduplicated number of children who received at least 2 topical fluoride applications as (a) dental OR oral health services. • Unduplicated number of enrolled children who ever received sealants on a permanent first molar tooth: (a) at least one sealant and

		• Unique members with 6+ month coverage who have ever received a dental sealant-code 1351, 1352 and/or have had all four molars sealed by 10th birthdate. • Number of unique adults aged 30 and older with a of periodontitis who receive a comprehensive (D0150) or periodic oral evaluation (D0120) or a comprehensive periodontal evaluation (D0180) within the reporting year.
Improve Oral Health Equity among Medicaid Members	• Monitor dental access by Race, Ethnicity, Age, and Gender • Increase race and ethnicity and social determinants of health reporting among the DWP population. • Increase benefit utilization for special populations. • Increase access for special populations	• Number of unique members in DWP Adult population that complete an OHEA within 12 months of consecutive coverage period. • Number of unique members who utilized any dental service by race, age group, and gender. • Number of unique members who had an oral evaluation who identify as black.
Improve Coordination and Continuity of Care between MCPs (managed care plans) – enhance medical/dental integration	• Decrease adult members who accessed the Emergency Department for non-traumatic, preventable dental conditions. • Increase adult members who receive follow-up dental services after Emergency Department visits for non—traumatic, preventive dental conditions within 7 days and 30 days. • Decrease child members who accessed the Emergency Department for caries-related emergency reasons. • Increase the number of child members who receive follow-up dental services after Emergency Department Visits for caries-related reasons within 7 days and 30 days.	• Number of emergency department visits for preventable reasons per 100,000 member months • Percentage of ambulatory care sensitive Emergency Department visits for preventable reasons in the reporting period for which the member visited a dentist within dental visit within a) 7 days. • Percentage of ambulatory care sensitive Emergency Department visits for preventable reasons in the reporting period for which the member visited a dentist within dental visit within a) 30 days. • Number of emergency department (ED) visits for caries-related reasons per 100,000 member months for children. • The percentage of caries-related emergency department visits among children 0 through 20 years in the

	• Members who Receive a Topical Fluoride Application During a Well-Child Visit	reporting period for which the member visited a dentist within (a) 7 days of the visit. • The percentage of caries-related emergency department visits among children 0 through 20 years in the reporting period for which the member visited a dentist within (b) 30 days of the ED visit. • Unique number of members who receive a topical fluoride application (99188) during the fiscal year, as part of their well-child exam.

Quality Goals Measure Baseline and Trends

PHAP GOALS 2019 AND 2023

The 2019 PHAP Quality Strategy overall lacked strategic goals with aligning measurable goals to identify if goals were met. The pandemic during this period affected the ability to effectively track and trend data in a way that allowed us to understand if any system drivers were effective.

- Promote appropriate utilization of services within acceptable medical standards.
- Ensure access to cost-effective dental care through contract compliance by:
  - Timely review of PAHP network adequacy reports
  - Access to dental services and access to preventative dental services
- Comply with State and Federal regulatory requirements through the development and monitoring of quality improvement 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 the end of 2019 by:
  - Encouraging member engagement in dental care through completion of oral health risk assessment (HRA) and a tiered benefit structure that expands benefits for members receiving preventative services.
- Provide care coordination to members based on oral health risk assessment (HRA) by:
  - Quarterly monitoring of HRA completion within one year of enrollment.
- Ensure that transitions of care do not have adverse effects by:
  - Maintaining historical utilization file transfers between the Agency and PAHPs, including the information needed to effectively transfer members
- Promote quality standards in PAHP 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 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. 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.

Improve Network Adequacy and Availability of Services

- Increase the number of general dentists who actively see patients in the dental program.
- Increase the number of specialty dentists who actively see patients in the dental program.
- Increase the number of members who access any dental care in the year.

Findings
There has not been enough time to impact these goals.

Next Steps
HHS plans to combine both quality strategy and align strategic goals. A focus could be on improving access to dental care, coordination of whole person care, and health equity. These goals could fall under access to care and whole person care coordination.

Increase Recall and Prevention Services

- Members Who Received Preventive Dental Care
- Continued Preventative Utilization
- Members Who Received Two Topical Fluoride Applications
- Members Who Received a Dental Sealant
- Members Who Received a Dental Sealant on all Four Molars by Age 10
- Increase the percentage of enrolled adults aged 30 years and older with a history of periodontitis who receive maintenance care.

Findings
There has not been enough time to impact these goals.

Next Steps
HHS plans to combine both quality strategy and align strategic goals. A focus could be on improving access to dental care, coordination of whole person care, and health equity. These goals could fall under access to care.

Improve Oral Health Equity among Medicaid Members

- Monitor dental access by Race, Ethnicity, Age, and Gender
- Increase race and ethnicity and social determinants of health reporting among the DWP population.
- Increase benefit utilization for special populations.
- Increase access for special populations

Findings
There has not been enough time to impact these goals.

Next Steps
HHS plans to combine both quality strategy and align strategic goals. A focus could be on improving access to dental care, coordination of whole person care, and health equity. These goals could fall under Health Equity.

Improve Coordination and Continuity of Care between MCPs (managed care plans) – Enhance Medical/Dental Integration

- Decrease adult members who accessed the Emergency Department for non-traumatic, preventable dental conditions.

- Increase adult members who receive follow-up dental services after Emergency Department visits for non—traumatic, preventive dental conditions within 7 days and 30 days.
- Decrease child members who accessed the Emergency Department for caries-related emergency reasons.
- Increase the number of child members who receive follow-up dental services after Emergency Department Visits for caries-related reasons within 7 days and 30 days.
- Members who Receive a Topical Fluoride Application During a Well-Child Visit

Findings
There has not been enough time to impact these goals.

Next Steps
HHS plans to combine both quality strategy and align strategic goals. A focus could be on improving access to dental care, coordination of whole person care, and health equity. These goals could fall under coordination of whole person care.

MANAGED CARE ORGANIZATION GOALS

Quality Goal One Behavioral Health

Promote behavioral health by measuring FUH/FUM for pediatric and adult populations. Measuring FUH/FUM for all member stratified by LTSS and Health Home.

- 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 a SUD Health Home Program
- U of I pre-print measures FUH/FUM for adult and children

Measure	Baseline CY2019	CY2020	CY2021	CY2022
FUH – AD 7 day/30 day	33.9%/55.8%	32.5%/51.9%	38.8%/57.4%	41.2%/61.5%
FUH – CH 7 day/30 day	42.3%/66%	43.2%/62.5%	52%/70.8%	54.5%/75%
FUH-HH 7 day/30 day	65%/86.6%	62.1%/85.2%	68.4%/87.1%	NA
FUH – All Hospital DP 18+ 30 day	NA	NA	NA	66.5%
FUH – U of I Physician DP 7 day/30 day	45.7%/61.2%	59.7%/69.4%	52.2%/67.3%	NA
FUH – U of I Physician DP 21+ 7 day/30 day	30.8%/56.9%	36.6%/60.6%	34.5%/57.6%	NA

FUH – U of I Physician DP 6-20 7 day/30 day	24.9%/66.4%	43.3%/63.4%	52.8%/75%	NA
FUH – AD – MCO P4P ITC	NA	NA	40.55%/60.49%	48.89%/69.15%
FUH – CH – MCO P4P ITC	NA	NA	58.71%/82.58%	68.22%/86.38%
FUH – AD – MCO P4P AGP	NA	54.07%/71.65%	55.53%/73.09%	55.53%/73.09%
FUH – CH – MCO P4P AGP	NA	63.54%/81.85%	65.74%/82.79%	65.74%/82.79%
FUM – AD 7 day/30 day	33.2%/49.9%	35.5%/52.2%	40.4%/55.9%	34.7%/52.1%
FUM – CH 7 day/30 day	NA	NA	52.1%/74.4%	50.6%/74%
FUM – HH 7 day/30 day	35.2%/46.9%	36.6%/45.4%	35.3%/48.1%	CH 62.1%/85% AD 53.9%/72.3%
FUM – MCO P4P – ITC	NA	NA	59.61%/70.80%	59.6%/70.80%
FUM – MCO P4P – AGP	NA	NA	62.28%/72.73%	62.28%/72.73%
FUM – U of I Physician DP 7 day/30 day	45.7%/61.2%	59.7%/69.4%	52.2%/67.3%	NA

CY2022 & 2023 EQR Technical Report Findings and Recommendations.

Findings CY2022:
Ranked at or above the 90th percentile.
- Follow-Up After ED Visit for AOD Abuse or Dependence.
- Follow-Up After ED Visit for Mental Illness.
- Follow-Up After Hospitalization for Mental Illness; and Initiation and Engagement of AOD Abuse or Dependence Treatment

Ranked at or above the 75th percentile but below the 90th percentile.
- Follow-Up After Hospitalization for Mental Illness

Ranked at or above the 50th percentile but below the 75th percentile.
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications and the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.

Ranked at or above the 25th percentile but below the 50th percentile.
- Diabetes Monitoring for People With Diabetes and Schizophrenia

Ranked below the 25th percentile.
- Metabolic Monitoring for Children and Adolescents on Antipsychotics

Findings CY2023:
Ranked at or above the 90th percentile.

- Follow-Up After ED Visit for Mental Illness
- Follow-Up After Hospitalization for Mental Illness measures.

Adult members who have co-occurring physical and mental health diagnoses (i.e., diabetes and schizophrenia or diabetes and bipolar disorder) and children and adolescents prescribed antipsychotics, HEDIS results indicate opportunities for the Iowa Managed Care Program to focus efforts on improving the management of these conditions.

Findings and Recommendations Network Adequacy Validation 2023:
Utilization data were obtained through the NAV activity, which focused on an analysis of behavioral health providers who saw new pediatric patients during CY 2022.

- 26 percent of Amerigroup's behavioral health providers had a visit with at least one new pediatric patient in CY 2022, indicating that some pediatric members looking for new behavioral health services were able to access services.
- 74 percent of Amerigroup's behavioral health providers did not have a visit with at least one new pediatric member in CY 2022. This could be a result of fewer new pediatric members requesting behavioral health services, or that the behavioral health provider is not accepting new behavioral health pediatric patients.
- 23.8 percent of Iowa Total Care's behavioral health providers had a visit with at least one new pediatric patient in CY 2022, indicating that some pediatric members looking for new behavioral health services were able to access services.
- 76.2 percent of Iowa Total Care's behavioral health providers did not have a visit with at least one new pediatric member in CY 2022. This could be a result of fewer new pediatric members requesting behavioral health services or that the behavioral health provider is not accepting new behavioral health pediatric patients.

These utilization metrics are not indicative of better or worse performance, and further analysis would be needed to determine if potential access issues exist. MCOs should review the results of the NAV activity, conduct ongoing internal reviews of behavioral health utilization, and monitor for any barriers that may impede a new pediatric member from receiving behavioral health services.

Recommendations CY2022: HSAG recommends that HHS consider revising its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective apply to the MCOs, PAHPs, or both.

Additionally, while HHS requires the MCOs to conduct two mandated PIPs, HHS could add a provision to the contract requiring the MCOs to engage in two additional PIPs per year (e.g., two HSAG-validated PIPs and two non-HSAG validated PIPs). HHS could specify the topics or areas the PIPs must address. One of these topics could be related to behavioral health. Further, HHS could consider setting MPSs or performance thresholds for a select number of HEDIS performance measures which align with HHS' Quality Strategy goals. While these performance thresholds may or may not be tied to a payment incentive, setting a statewide performance threshold will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress in meeting HHS' established Quality Strategy goals and objectives.

Recommendations CY2023: Due to the success of the behavioral health related pay-for-performance measure (i.e., Follow-Up After Hospitalization for Mental Illness), HHS should consider expanding or replacing its existing pay-for-performance measures to include one or more of the lower-performing HEDIS measures (e.g., Metabolic Monitoring for Children and Adolescents on Antipsychotics).

HHS could mandate the MCOs to conduct a PIP that focuses on improving the management of children and adolescents on antipsychotics and/or adults who have co-occurring physical and mental health diagnoses. Further, HHS' existing MCO Quality Strategy does not include measurable performance metrics for most goals.
Finally, HHS should require calculation of the mandatory CMS Core Set measures by MCO. HHS could accomplish this by requiring its MCOs to calculate and report on each mandatory Core Set measure or contract with its existing vendor to calculate each mandatory Core Set measure by MCO, in addition to calculating the statewide aggregate rates for each measure.

State's Response:

Findings
The State's goal was to improve behavioral health but did not set specific benchmarks and goals for improvement. Much of the three years Managed Care P4P for FUH and FUM measures were leveraged as well as HSAG Network Adequacy Validation Study, Integrated Health Home Workgroups to identify program improvements, incorporated behavioral health in our directed payments and the managed care health equity plans, and more recently submitted for a demonstration grant to implement CCBHCs to focus on BH and SUD.

- Managed Care Pay for Performance Measures have been successful at improving follow-up after hospitalizations and ED visits.
- Managed Care Health Equity Plans focused on BH and SUD noting a disparity in Black and Latinx members, more specifically related to depression medication adherence, and follow-up after hospitalization. Amerigroup is focused on improving their case management dashboard, increased housing initiatives, built reginal provider and community relationships and partnerships, and included value added benefits to support members with a BH and SUD diagnosis. Iowa Total Care is focused on provider training for Follow-up after Hospitalization, provider summit that addresses SDOH and Health Equity, expand community health workers, post discharge text campaigns.
- HSAG Behavioral Health Network Adequacy: monitor for any barriers that may impede a new pediatric member from receiving behavioral health services.
- Integrated Health Home Workgroup: Update the tiering and payment system to be more reflective of the population risk and reduce provider burden, change the eligibility criteria to allow more ways a member can qualify, expand the care coordinator requirements to address workforce issues.
- Iowa Total Care QM Improvement Plan 2023.
    - Identified Access issues through data in the outpatient space and through appeals. Members felt that they were not informed about treatment options or managing their conditions.
    - Identified the need to improve medication monitoring.
    - The top SDOH issues where housing, transportation, and health literacy.
    - Top diagnosis: anxiety, major depression disorder, ADHD, and PTSD.
    - They noted a high suicide and have a program called choose tomorrow.
    - Other programs: Bridge to care project, Halo Program for SUD, and implement an SUD Toolkit.
- Amerigroup now Wellpoint QM Plan
    - The plan did not provide clear identifications of areas of improvement and goals, but goals were primarily quality assurance goals in order to meet standards.
- Directed Payments
    - U of I Hospital expanded the CoCM model and hired additional mental health providers. They also hired crisis safety officers as well as a training program. They partnered to expedite a pathway for those that do not have guardians and collaborate with MHDS to support community-based system of care.
    - U of I Physician introduced care coordinators for transitions in care activities.

Next Steps

Managed Care Pay for Performance Measures. Remove FUH/FUM and add:

- Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose Screening
- Metabolic Monitoring for Children and Adolescents on Antipsychotics – Cholesterol Testing
- Community Based Behavioral Health (B3) Service Project Plan

Managed Care Health Equity:

- Focus on the development of an HHS Health Equity Plan
- Have all Managed Care Plans complete a Health Equity Plan for SFY2026
- Identify measures that can be stratified such as CMS Core Measures and HEDIS Measures.

HSAG Behavioral Health Network Adequacy:

- SFY 2025 all MCOs are required to develop a plan to improve access and network adequacy to B3 services, we will ensure that Pediatrics are an area of focus.
- Parter with the managed care plans to improve in identifying behavioral health provider types to improve assessing access to behavioral health services.

Integrated Health Home:

- Redesign the Health Home Program to improve outcomes, reduce provider barriers, and increase access to whole person care coordination.

Certified Community Behavioral Health Clinics (CCBHC):

- Improve outcomes for members with BH and SUD diagnoses through CCBHC Demonstration.

QAPI:

- Attend Managed Care Plan quality committee meetings.

Directed Payments:

- U of I Hospital and Physician: Improve outcomes for high intensity behavioral health patients, including diversion from Iowa's criminal justice systems, leading to potential cost reductions for Iowa's overall system of care. support additional growth in psychiatric and behavioral health services by investing in additional physical space for outpatient visits as well as growing telehealth services and inpatient care. evaluate new training, partnerships with community providers and managed care organizations to develop pilot programs, and partnerships to scale community-based behavioral health services to better address the needs of these high-intensity populations.
- All Hospital: Has a goal to improve follow up after hospitalization for mental illness. Their plan will be available May of 2025. The state will ensure that it aligns with the 2024 Quality Strategy.

Quality Goal Two Access to Care

Increase Access to Care.

- Increasing covered lives in value-based purchasing arrangements at a minimum of 40%.
- Improve network adequacy.
- Improve timeliness of Postpartum Care: Primary Cesarean Rate
- Increase access to primary care and specialty care: GEMT, Primary Care

Measure	Baseline CY2019	CY2020	CY2021	CY2022
Outpatient In-Person Office	NA	313,991	380,543	385,645

Visits – U of I Hospital DP				
Outpatient In-Person Office Visits – U of I Physician DP	330,285	313,991	380,543	385,645
Telehealth Visits – U of I Hospital DP	NA	33,643	22,244	17,358
Telehealth Visits – U of I Physicians DP	2,245	33,643	22,244	17,358
ED Encounters – U of I Hospital DP	NA	13,500	14,143	14,601
ED Encounters – U of I Physicians DP	15,730	13,500	14,143	14,601
Inpatient Encounters – U of I Hospital DP	NA	7,423	7,492	7,736
Inpatient Encounters – U of I Physicians DP	7,603	7,423	7,492	7,736
Mental Health Outpatient Encounters – U of I Hospital DP	NA	20,792	21,153	22,354
Mental Health Inpatient Discharges – U of I Hospital DP	NA	626	535	439
Maternal Health Outpatient Encounters – U of I Hospital DP	NA	NA	NA	11,519
Maternal Health Inpatient Encounters – U of I Hospital DP	NA	NA	NA	1,100
Postpartum Visit Within 8 Weeks – U of I Physician DP	51.2%	50.5%	54.9%	59%
Primary Cesarean Delivery Rate	NA	NA	11.9%	12.7%

Uncomplicated – All Hospital DP				
Low-Risk Cesarean Delivery – CH	24.2%	25.9%	23.3%	23.2%
Percentage of Low Birthweight Births – CH	7.7%	7.4%	7%	7.4%
Postpartum Care – AD	43.9%	39.2%	41.2%	26.7%
Prenatal Care – CH	75.7%	75.4%	75.9%	53.4%
% of transports that did not result in an admission – GEMT DP	Calculating			
% of ambulance trips that resulted in treatment but no transport – GEMT DP	Calculating			
Members in a VBP - ITC	24%	84%	96%	99%
Members in a VBP - AGP	41%	49%	63%	64%

CY2022 & 2023 EQR Technical Report Findings and Recommendations.

Findings CY2022: The results of the HEDIS activity demonstrated mixed results program wide related to primary and specialty care (excluding behavioral health and prenatal and postpartum care which are addressed under a different HHS Quality Strategy goal):

- Access to Preventive Care domain—One performance measure rate ranked at or above the 75th percentile but below the 90th percentile, two rates ranked at or above the 50th percentile but below the 75th percentile, three rates ranked at or above the 25th percentile but below the 50th percentile, and one rate ranked below the 25th percentile.
- Women's Health domain—Two performance measure rates ranked at or above the 50th percentile but below the 75th percentile, two rates ranked at or above the 25th percentile but below the 50th percentile, and two rates ranked below the 25th percentile.
- Living With Illness domain—One performance measure rate ranked at or above the 90th percentile, two rates ranked at or above the 75th percentile but below the 90th percentile, three rates ranked at or above the 50th percentile but below the 75th percentile, and two rates ranked below the 25th percentile.
- Keeping Kids Healthy domain—One performance measure rate ranked at or above the 75th percentile but below the 90th percentile, five rates ranked at or above the 50th percentile but below the 75th percentile, one rate ranked at or above the 25th percentile but below the 50th percentile, and one rate ranked below the 25th percentile.
- Medication Management domain—Two performance measure rates ranked at or above the 75th percentile but below the 90th percentile, seven rates ranked at or above the 50th percentile but below the 75th percentile, eight rates ranked at or above the 25th percentile but below the 50th percentile, and one rate ranked below the 25th percentile.

- Program wide— the highest-ranking performance measure was Comprehensive Diabetes Care—HbA1c Testing, while the lowest ranking performance measures included Use of Imaging Studies for Low Back Pain, Chlamydia Screening in Women, Statin Therapy for Patients With Cardiovascular Disease, Statin Therapy for Patients With Diabetes, Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits, and Pharmacotherapy Management of COPD Exacerbation—Bronchodilator.

Findings CY2023: Based on HEDIS results, many adult and child members were accessing preventive medical care.

- Access to Preventive Care and Keeping Kids Healthy domains performing at or above the national Medicaid 50th percentile. HEDIS results, as indicated by performance at or above the national Medicaid 50th percentile, also indicated that many child and adolescent members were receiving recommended immunizations.
- Women's Health domain, many adult and adolescent women were getting screened for breast cancer and/or cervical cancer.
- Keeping Kids Healthy domain, many children were getting lead screenings as recommended.
- Living With Illness domain, performance measure rates indicated that many members with diabetes and hypertension were being managed appropriately, as indicated by performance at or above the national Medicaid 50th percentile. These positive results indicate that members were able to access providers to obtain services, which was supported by positive member experiences (i.e., performance at or above 82.7 percent) in the Getting Needed Care and Getting Care Quickly statewide adult and child CAHPS results. These results also support that progress was made toward the Iowa Managed Care Program achieving the objective to increase access to primary care and specialty care.
- HHS also required the MCOs to develop a PIP that focused on timeliness of postpartum care. As indicated by the statewide rate for the Prenatal and Postpartum Care—Postpartum Care measure, the Iowa Managed Care Program is performing at or above the national Medicaid 50th percentile, indicating that women who had recently delivered were following up in a timely manner with their providers. Timely and adequate postpartum care can support positive health outcomes for new mothers and their infants. This higher performance also supports the Iowa Managed Care Program's progress toward achieving the improve timeliness of postpartum care objective under the Access to Care goal and the improve the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes objectives under the Improving Coordinated Care goal.

Recommendations CY2022:

- HHS could also add a provision to the contract requiring the MCOs to engage in two additional PIPs per year (e.g., two HSAG validated PIPs and two non-HSAG validated PIPs). HHS could specify the topics or areas the PIPs must address. Options for these topics could include prevention and care of acute and chronic conditions, high-risk services, oral health, etc.
- HHS could update its network adequacy standards to include minimum required provider-to-member ratios for PCPs, specialists, and dentists.
- HHS could consider a disruption analysis in future NAV activities. A disruption analysis may provide HHS with valuable information on whether members retained access to their PCPs, and whether provider networks and time/distance access standards were impacted.
- HHS could consider setting MPSs or performance thresholds for a select number of HEDIS performance measures which align with HHS' Quality Strategy goals. While these performance thresholds may or may not be tied to a payment incentive, setting a statewide performance threshold will assist HHS in quantitatively evaluating the Iowa Medicaid Managed Care Program's progress in meeting HHS' established Quality Strategy goals and objectives.

State's Response:

Findings:
Because we didn't have SMART goals with specific measures and benchmarks, it was difficult to determine if these goals were met.

- Increasing covered lives in value-based purchasing arrangements at a minimum of 40%
- Improve network adequacy.
- Improve timeliness of Postpartum Care: Primary Cesarean Rate
- Increase access to primary care and specialty care: GEMT, Primary Care

Next Steps

- Increase covered lives in value-based purchasing arrangements at a minimum of 40%
  - Discuss with the Quality Committee if we want this in a specific area such as prenatal and postnatal care or behavioral or dental.
- Improve network adequacy.
  - Dental and BH focus.
  - Network adequacy standards to include minimum required provider-to-member ratios for PCPs, specialists, and dentists.
  - Disruption analysis in future NAV activities. A disruption analysis may provide valuable information on whether members retained access to their PCPs, and whether provider networks and time/distance access standards were impacted.
- Improve timeliness of Postpartum Care: Primary Cesarean Rate. Primary Cesarean Rates is not a metric we chose to continue.
  - Maternal Health Social Drivers: Transportation and food insecurities. In our Health Risk Assessments, we identified food insecurities and transportation issues. We have implemented Mom's Meals as a pilot program as well as transportation to get food and other things they need.
  - Expanding Medicaid to 12 months postpartum.
  - Assessing Managed Care Postpartum Case Management to ensure access to coordinated care (includes HRA pre- and post-partum) to identify SDOH, mental health and substance use disorder needs.
  - Focus on maternal morbidity and mortality reduction.
- Increase access to primary care and specialty care: GEMT, Primary Care.
- Add a provision to the contract requiring the MCOs to engage in two additional PIPs per year (e.g., two HSAG validated PIPs and two non-HSAG validated PIPs). Prevention and care of acute and chronic conditions, high-risk services, oral health, etc. for SFY2026.
- MPSs or performance thresholds for a select number of HEDIS performance measures which align with HHS' Quality Strategy goals for SFY2026.

Quality Goal Three Program Administration

- Meet measure thresholds for Timely Claims Reprocessing and Encounter Data.

Measure	Baseline CY2019	CY2020	CY2021	CY2022
Timely Claims Reprocessing - AGP	100%	100%	100%	100%
Timely Claims Reprocessing - ITC	99%	100%	99%	97%
Encounter Data submitted Timely - AGP	Yes	Yes	Yes	Yes

Encounter Data submitted Timely - ITC	Yes	Yes	Yes	Yes

State's Response:

Findings:
Our goal was to meet measure thresholds. We did not set goals to improve.
- MCOs met measure thresholds for Timely Claims Reprocessing and Encounter Data.

Next Steps
- There needs to be identified benchmarks for program administration as an example, number of appeals. We are currently trending data and identifying how the data definitions are interpreted to ensure accuracy of the data prior to benchmarks being established.

Quality Goal Four Decrease Cost of Care

- Reducing the rate of potentially Preventable readmissions and non-emergent ED visits.

Measure	Baseline CY2019	CY2020	CY2021	CY2022
All-Cause Readmission expected/observed ratio	.9812	.9687	.9646	.8131
Ambulatory Care ED Visits Total (CH)	39.3%	25.31%	31.31%	33.9%

State's Response:

Findings:
- Our goal was to meet Reducing the rate of potentially Preventable readmissions and non-emergent ED visits. We remained steady and are below the median of reported states.

Next Steps
- Set goals for reducing the total cost of care. We plan to discuss with each Bureau to identify areas of opportunity to reduce the total cost of care.

Quality Goal Five Improving Coordinated Care

- 70% of HRAs will be completed withing 90 days of enrollment and annually.
- Improve Postpartum visit rate.
- Improve 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.

Measure	Baseline CY2019	CY2020	CY2021	CY2022
HRA completion rates AGP	82.4%	85.53%	65.86%	74.14%

HRA completion rates ITC	90.72%	87.69%	78.11%	97.84%
Improve Postpartum visit rate	43.9%	39.2%	41.2%	26.7%
All Cause Readmission – All Hospital DP	NA	NA	5.8%	6.3%
Gestational glucose screening rates U of I	94.7%	92.8%	96.2%	96.1%
Needs based eligibility assessment rates - AGP	98%	100%	100%	100%
Needs based eligibility assessment rates - ITC	NA	99%	99%	100%
***Initial and annual service plan review and updates completion - AGP**	81.27%	98.24%	98.83%	99.04%
***Initial and annual service plan review and updates completion - ITC**	96.81%	99.13%	96.15%	96.14%

*does not include exceptions

CY2022 & 2023 EQR Technical Report Findings and Recommendations.

Findings CY2022:

MCO PIP: Timeliness of Postpartum Care.

- Amerigroup's performance indicator achieved a rate of 76.9 percent, demonstrating a statistically significant improvement from the baseline rate which was 68.9 percent.
- Iowa Total Care also demonstrated programmatically significant improvement over the baseline performance through the implementation of provider education and member outreach which increased the number of pregnancy notifications received by the MCO from 2020 to 2021.
- Timeliness of Postpartum Care indicator under the Prenatal and Postpartum Care performance measure ranked at or above the 50th percentile but below the 75th percentile, indicating many women had a postpartum visit on or between seven and 84 days after delivery of their baby.
- Improving Coordinated Care, the related Timeliness of Prenatal Care rate under the Prenatal and Postpartum Care performance measure ranked below the 25th percentile, indicating that many pregnant women receiving services under the Iowa Managed Care Program did not

receive a timely prenatal care visit within the first trimester. Prenatal care is critical in ensuring healthy outcomes for new mothers and their babies, including a healthy birth weight.

The EQRO recommends updating our current Quality Strategy goals to include a measurable objective related to the HCBS performance measures.

Findings CY2023:
MCO PIP that focused on timeliness of postpartum care. As indicated by the statewide rate for the Prenatal and Postpartum Care—Postpartum Care measure, the Iowa Managed Care Program is performing at or above the national Medicaid 50th percentile, indicating that women who had recently delivered were following up in a timely manner with their providers. Timely and adequate postpartum care can support positive health outcomes for new mothers and their infants. This higher performance also supports the Iowa Managed Care Program's progress toward achieving the improve timeliness of postpartum care objective under the Access to Care goal and the improve the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes objectives under the Improving Coordinated Care goal.

Recommendations CY2022:
While the Iowa Managed Care Program is performing poorly when compared to national percentiles related to timely prenatal care, both MCOs demonstrated an improvement in performance from MY 2020 to MY 2021 (for Amerigroup, the rate increased 3.41 percentage points and for Iowa Total Care, the rate increased by 5.84 percentage points).

The percentage of low birth weights for the Iowa Medicaid and CHIP population is 7.7 percent, which is below the national median rate of 9.7 percent (a lower rate indicates better performance). HHS should closely monitor year-over-year and long-term trending for the Timeliness of Prenatal Care rate and low birth weight for the Iowa Medicaid population for continued improvement.

HHS should implement statewide improvement initiatives for any noted decrease in performance (i.e., decrease is the Timeliness of Prenatal Care rate, increase in low-birth-weight rates, and the correlation between the two measures). HHS could consider a statewide collaborative to identify the impact that untimely prenatal care has on member outcomes such as live births, low birth weight and pre-term births, and the financial impact to the Iowa Medicaid Managed Care Program due to poor outcomes.

Recommendations CY2023:
Establishing a statewide performance benchmark will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress in meeting HHS' established MCO Quality Strategy goals and objectives.
HHS should require its MCOs to conduct routine secret shopper surveys of their provider networks to assess compliance with network adequacy and appointment availability standards.

State's Response:

Findings:
- 70% of HRAs were completed withing 90 days of enrollment and annually.
- There is an identified need to improve prenatal visit rates. Work with the Maternal Health Task Force and Iowa Maternal Quality Care Collaborative to improve prenatal care.
- Improve Postpartum visit rate. This dropped instead of increased based on the CMS Core measures which is administrative only. This is in the MCO Health Equity Strategies, was a P4P, and PIP.
    - Maternal Health Task Force
    - IMQCC Stakeholder Advisory Committee
- 100% timely completion of level of care and needs based eligibility assessments goal was met and a new goal needs to be identified.

- 100% timely completion of the initial and annual service plan review and updates.
    - Chose HCBS Metrics and goals that improves outcomes for members.

Next Steps
Health Risk Assessments
- PIP with the goal to move from completing to identifying risks and coordinating.

Postpartum Visit Rate
- Transportation to get food. Project started to provide transportation for doctor's appointments, food etc.
- Increase case management postpartum.
- Expanding Medicaid to 12 months postpartum.

Focus on "Timeliness of Prenatal Care" rate under the Prenatal and Postpartum Care performance measure ranked below the 25th percentile, indicating that many pregnant women receiving services under the Iowa Managed Care Program did not receive a timely prenatal care visit within the first trimester. Prenatal care is critical in ensuring healthy outcomes for new mothers and their babies, including a healthy birth weight.

Improve glucose screening for gestational diabetes. Change this goal to improve social drivers of health. HRAs identified:
- Significant food insecurities. Moms Meals as pilot programs. Monthly reports on meals (pre/post) and family members.
- Transportation to get food. Project started to provide transportation for doctor's appointments, food etc.

Expanding Medicaid to 12 months postpartum.
- Increase case management postpartum including increase in HRAs.
- Address access to address their MH and SUD needs.
- Maternal Morbidity and Mortality review process.

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.
- HHS is requiring the MCOs to complete an LTSS Project as a Pay for Performance measure. This project requires them to address causes for members not receiving needed services and timeliness for needed services. We allow exceptions for timelines and expect the MCOs to reduce the number of exceptions with the goal to improve timeliness to service. This project includes community education. The draft plan is required September of 2024 with implementation June 30, 2025.
- Changing the ride along oversight to be a statistically significant sample and will include additional questions to ensure restrictive interventions and core elements have been identified.

Consider requiring its MCPs to conduct routine secret shopper surveys of their provider networks to assess compliance with network adequacy and appointment availability standards.

Quality Goal Five Continuity of Care

- 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.
- Monitoring transition and discharge planning for Long-Term Services and Supports (LTSS) members.

Measure	Baseline CY2019	CY2020	CY2021	CY2022
MDS section Q	Unable to obtain a denominator for an accurate report			
IPES Member Survey	Specific measures were not identified			
Ride Alongs	Specific measures were not identified			

CY2022 & 2023 EQRO Technical Report Findings and Recommendations.

Findings CY2022: HSAG noted that there was a focus on a set of state-specific performance measures related to members receiving home and community-based services (HCBS) and the provision of person-centered care planning. Through the person-centered care planning process, the MCOs should also be addressing transitions of care between care settings. One of the measures validated through the Performance Measures Validation activity is Member Choice of Home and Community-Based Services (HCBS) Settings. A member's care plan must document the member's choice and/or placement in alternative HCBS settings. Should a member be transitioning from one setting to another setting, the person-centered planning process should address continuity of care and access to services during the transition.

State's Response:

- Ensuring the accuracy and completeness of member information needed to efficiently and effectively transition members between plans and/or providers.
    - HHS implemented a member lookup tool that pulls information from our mainframe for access to 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.
    - 456 review process, MDS Section Q discharge plans MCO quarterly reports. MCO and LTC is assigned a Facility based CM.
- Monitoring transition and discharge planning for Long-Term Services and Supports (LTSS) members.

Next Steps:

- Consider measuring, creating benchmarks for the following areas as it relates to continuity of care:
    - Assessment
    - Person-centered care planning
        - Member's choice and/or placement in alternative HCBS settings.
        - Address transitions to another setting
        - Discharge planning
    - Residential settings
    - Incident reporting
    - Survey questions that relate to continuity of care

Quality Goal Six Health Equity

Iowa Medicaid Quality Committee meets quarterly with each MCO to review progress on Health Equity.

- Identify Health disparities or inequities and target those areas for improvements.
- Monitor the implementation and progress of the Health Equity Plans

AGP Health Equity

- Asthma 5.3% disparity in the Black population with the goal to increase asthma medication adherence rate.
- Diabetes 2.1% disparity in the Black population with the goal to increase blood test rate of black members with a diagnosis of diabetes.
- Maternal-Child: Low Birth Weight 6.87% disparity in the Black population with the goal to decrease the low-birth-weight rate.
- Maternal-Child Health Prenatal and Postnatal Care 4.7% disparity in the Black population with the goal to increase timelines of prenatal and postnatal care.
- Behavioral Health and Substance use disorder with the goal to increase adherence rates for each measure and population by 5%.
  - Anti-depressant medication adherence rate
    - Rural: Black 8.7%, Latinx 10.9%
    - Urban: Black 14%, Latinx 6.4%
  - Initiation and engagement of treatment
    - Urban Black 9.3%
  - Follow-up after hospitalizations for mental illness
    - Rural Latinx 9.4%
    - Urban Black 9.3%
- Community Integration: Lack of HCBS services and supports in rural communities for individuals with disabilities which creates barriers for members wanting to transition from state resource centers or other facility-based care settings with the goal to assist members who desire transition to community and increase LTSS members serviced in a community setting.
- Social Determinates of Health: Use vendors to coordinate SDOH needs.

ITC Health Equity

- Increase capture of race, ethnicity, language, and sexual orientation or gender identity
- Increase health risk assessment completion rates.
- Low Birthweight Performance with the goal to decrease low birth rates in the following counties: Black Hawk (2.7%), Scott (2.3%) and Woodbury (2.6%)
- Breast Cancer Screening Performance with the goal to decrease overall noncompliance by 5% in Wapello and Des Moines Counties.

CY2022 & 2023 EQR Technical Report Findings and Recommendations.

Findings CY2022: The results of the MCO NAV activity demonstrated that 100 percent of members have access to an adult PCP; 100 percent of members have access to a pediatric PCP; 100 percent of members have access to a behavioral health inpatient provider; and almost 100 percent of members have access to a behavioral health outpatient provider. These results confirm there were no or minimal variations by member urbanicity, race/ethnicity, age, or living in an area of concentrated disadvantage.

HHS has implemented a pay-for-performance (P4P) program to reward the MCOs' efforts to improve quality and the health outcomes of members. The SFY 2022 program included a performance measure related to the MCOs' health equity plans. To receive the incentive payment, the MCOs were required to submit a health equity plan that includes but is not limited to policies and procedures that demonstrate organizational attention to health equity focus areas; strategic goals; the measures and metrics used to track progress toward achieving the strategic goals; and measurement and evaluation of each strategic goal.

Through the compliance review activity and quality assessment and performance improvement (QAPI) program, one MCO was a recipient of the National Committee for Quality Assurance (NCQA) Distinction in Multicultural Healthcare. Both MCOs also adhered to national culturally and linguistically appropriate services (CLAS) standards to identify and reduce care deficiencies related to CLAS and health disparities.

Findings CY2023: The CY 2023 EQR activity results (i.e., PIP, PMV, compliance review, NAV, EDV, and CAHPS) did not produce data to comprehensively evaluate the Iowa Managed Care Program's performance impact on health equity with the MCOs in support of the Health Equity goal within the MCO Quality Strategy or the PAHPs in support of Goal 3, improve oral health equity among Medicaid members, of the PAHP Quality Strategy.

Recommendations CY2022: While HHS' contract with the PAHPs requires the PAHPs to deliver services to all members in a culturally competent manner, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity, it did not include any specific provisions addressing health equity in dental care. HHS could consider strengthening contract language to address health equity; for example, requiring the PAHPs to conduct an assessment of existing health disparities, including disparities identified through the results of performance measure reporting, and develop a formal health equity plan. HHS could also consider applying the MCO NAV activity methodology to the PAHP NAV activity and stratify PAHP results by race/ethnicity, urbanicity, age, and a concentrated disadvantage index.

Recommendations CY2023: HHS' existing MCO Quality Strategy does not include measurable objectives that promote performance improvement. Therefore, HHS should establish objectives with minimum performance standards or performance thresholds that address health equity and target specific program areas where inequities are identified. HHS could also consider requiring a health equity focus for the next cycle of new PIPs for both the MCOs and PAHPs.

State's Response:

State Findings:
It is not clear if a reduction in disparities occurred in the areas addressed in their original Health Equity Plan. The MCOs did identify an increase in staff training, collaboration in the community, increase in programs to address issues, and provided success stories that described their work. The Quality Committee should provide additional feedback and direction to the MCPs around Health Equity. Dental has been siloed and not included in this goal.

Next Steps:

- In SFY 2026 P4P for both PAHPs and MCOs should include Health Equity as a project as we have not included the newest MCO nor the PAHPs in this exercise.
- Include oversight that requires a clear reporting of reduction in disparities in the identified areas.
- Identify disparities across the Medicaid membership to identify recommendations for areas of focus for the MCPs.
- Apply the MCO NAV activity methodology to the PAHP NAV activity and stratify PAHP results by race/ethnicity, urbanicity, age, and a concentrated disadvantage index.

Quality Goal Seven Voice of the Customer

- Annually review the CAHPS results and make recommendations for improvement.
- Quarterly review the HCBS IPES results and make recommendations for improvement.
- Quarterly review the appeals and grievance reports and make recommendations for improvement.

The Quality Committee used the EQR Technical Report review and recommendations for improvement around CAHPS, IPES, and appeals and grievances.

CY2022 & 2023 EQR Technical Report Findings and Recommendations.

Findings CY2022: HHS required the MCOs to conduct a PIP related to CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed. Both MCOs received an overall

validation status of Met, indicating the MCOs conducted appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement. While both MCOs demonstrated an increase in the Customer Service at Child's Health Plan Gave Information or Help Needed rate from the baseline rate to Remeasurement 1, the improvement was not statistically significant.

Program wide CAHPS rates indicate that no measure was statistically significantly lower than the 2021 national average. Further, rates for several measures were statistically significantly higher than the 2021 national average:

- Getting Needed Care and Getting Care Quickly for the adult population; and Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Rating of All Health Care, and Rating of Personal Doctor for the child population.

Iowa Participant Experience Survey (IPES) for members receiving HCBS.

- Standard XIV—Quality Assessment and Performance Improvement Program that both MCOs implemented the IPES and reported the results to HHS quarterly.
- Standard X—Grievance and Appeal Systems of the compliance review activity was 89 percent.

All MCPs demonstrated opportunities to improve implementation of grievance and appeal processes to ensure adherence to all federal and State contract requirements. Strict adherence to these requirements is needed to ensure the MCPs collect complete and accurate information to review reports and make recommendations for improvement, including increasing member satisfaction when concerns are identified.

Findings CY2023: The adult Medicaid population reported positive experiences in Getting Needed Care and Customer Service, as these scores (85.3 percent and 92.2 percent, respectively) were statistically significantly higher than the 2022 NCQA Adult Medicaid national average. For the child Medicaid population, the scores for Getting Needed Care and Getting Care Quickly were both statistically significantly higher than the 2022 NCQA Child Medicaid national average, with scores of 88.4 percent and 90.1 percent, respectively.

The adult Medicaid population, the top-box score for Rating of Specialist Seen Most Often was 60.9 percent and had a statistically significant decline, which suggests that some members may have been deterred from going to their specialists for care based on their negative personal experiences. Additionally, the top-box scores for Discussing Cessation Medications for the adult population and Rating of All Health Care for the child population were statistically significantly lower than the 2022 national average, indicating that additional opportunities exist for improving member experience in these areas.
HHS also required the MCOs to conduct a PIP with the topic CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed. Both MCOs received an overall validation rating of Met, indicating the MCOs conducted appropriate causal/barrier analysis methods to identify and prioritize opportunities for improvement, although both MCOs had a statistically significant decline in performance from the baseline measurement rate for CY 2023.

Recommendations CY2022: HHS could strengthen contract language by requiring the PAHPs to conduct a member satisfaction survey annually. Additionally, as HHS' Quality Strategy for the PAHPs does not specifically address member satisfaction, HHS could consider setting a PAHP performance objective under the Voice of the Customer overarching goal.

Recommendations CY2023: HHS' existing MCO Quality Strategy does not include measurable objectives that promote performance improvement. Therefore, HHS should establish minimum performance standards or performance thresholds for each Voice of the Customer-related objective. For example, HHS could set minimum performance standards for specific areas or domains of the CAHPS survey. Establishing a statewide performance benchmark will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress toward meeting HHS' established MCO

Quality Strategy goals and objectives. Additionally, as HHS' PAHP Quality Strategy does not specifically address member experience, HHS could consider setting a PAHP performance objective under the Voice of the Customer overarching goal. HHS could also consider requiring the PAHPs to contract with a CAHPS vendor to administer a CAHPS survey that has been modified to address dental care.

State's Response:

Findings: SMART goals were not identified for the voice of the customer. While some years MCOs scored higher than the national average, some questions have dropped in the recent year.

- Specialist Seen Most Often has declined suggests that some members may have been deterred from going to their specialists for care based on their negative personal experiences.
- Discussing Cessation Medications for the adult population
- Rating of All Health Care for the child population.
- Customer Service at Child's Health Plan

Improvement in the implementation of grievance and appeal processes to ensure adherence to all federal and State contract requirements.

Next Steps:

- Use the national average as a benchmark for CAHPS survey questions.
- Identify CAHPS survey questions that align with other goals within the Quality Strategy.
- Use the quality framework to review MCP practices for grievance and appeals ensuring they meet state and federal requirements, then identifying areas for improvement to increase member satisfaction when concerns are identified.

DENTAL PAHP GOALS

Since the Quality Strategy for PAHP CMS Feedback was provided in the most recent few months, a more formal evaluation will be included in a future evaluation. However, EQR did identify areas of alignment as we combine both PAHP and MCO Quality Strategy into one, also aligning strategic priorities.

Quality Strategy Alignment

IOWA MEDICAID STRATEGIC PLAN OCTOBER 2022

download (iowa.gov)

Objective 1: Identify and mitigate program gaps in meaningful service delivery.

- Behavioral Health Gap analysis report as part of the Community Based Services Evaluation.
- Evaluate service delivery and engagement through Health Equity lens by analyzing Behavioral health, maternal health, primary care, telehealth services and non-emergent ED visits services are accessed by:
    - Race
    - Ethnicity
    - Age
    - Geography
- Develop necessary maternal health coordination and reimbursement strategies that lead to appropriate risk identification and referrals that lead to better outcomes for mothers and children.
- Coordinate policy initiatives to ensure that oral health is a component of whole person health.

Objective 2: Shift program operations and planning to focus on outcomes.

- Overhaul managed care and professional services contracts to create balance between compliance and outcome monitoring.
- Evaluate the value of administrative processes, such as prior authorization and claims cycles, relative to member outcomes and return on investment.

Objective 3: Promote transparency in program development and performance.

- Engage internal and external stakeholders early and often in development and monitoring activities.
- Refine reports and dashboards so that they are reflective of stakeholder need.

Objective 4: Modernize Iowa Medicaid infrastructure and operations.

- Pursue technology solutions that support collaboration, data driven decisions, efficiency, and monitoring of program outcomes.

MANAGED CARE PLAN PAY FOR PERFORMANCE

The Quality Committee is charged with proposing pay for performance measures for Medicaid Division Administrators and Bureau Chief's review and approval. Our EQRO Technical Report, as managed care regulatory reports, and CMS Core Measures are used to assist in determining measures.

SFY2020

MCP	Measure
AGP/UHC	IDT Planning - Questions #12, #18, and #23
AGP/UHC	IPES - Questions 401 - Part of Service Planning
AGP/UHC	Claims Reprocessing - within 30 calendar days
AGP/UHC	Employment
AGP/UHC	ED Use
AGP/UHC	Encounter Data Reconciliation - for SFY19

SFY2021

MCP	Measure
AGP/ITC	Encounter Data
AGP/ITC	Timely Claims Reprocessing
AGP/ITC	FUH 7 day and 30-day Children and Adults
AGP/ITC	FUM 7 day and 30-day Adults
AGP/ITC	Long Term Services and Support: Balancing Towards Community-Based Services

SFY2022

MCP	Measure
AGP/ITC	Encounter Data
AGP/ITC	Timely Claims Reprocessing
AGP/ITC	FUH 7 day and 30-day Children and Adults
AGP/ITC	FUM 7 day and 30-day Adults
AGP/ITC	Health Equity Plan

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM

QAPI programs. The quality strategy must include the quality metrics and performance targets to be used in measuring the performance and improvement of each MCP, including but not limited to, the performance measures reported in MCP QAPI programs. States should include specific measures and targets from their quality strategies in their QAPI programs, with PIPs designed to drive improvement on those measures and attain those targets.

As demonstrated through the compliance review activity and quality assessment and performance improvement (QAPI) program, one MCO was a recipient of the National Committee for Quality Assurance (NCQA) Distinction in Multicultural Healthcare. Both MCOs also adhered to national culturally and linguistically appropriate services (CLAS) standards to identify and reduce care deficiencies related to CLAS and health disparities.

CMS REQUIRED PIPS

AGP PIP

Measure Year One

Amerigroup demonstrated a statistically significant improvement over one measurement year for timeliness of postpartum care. To improve this measure, the plan provided telephonic outreach to members who needed a postpartum visit. They also educated providers participating in their provider quality incentive program and attempted to gain remote access to electronic heath records to obtain the needed information but was not successful.

Amerigroup did not demonstrate a statistically significant improvement for the CAHPS measure. Interventions included training for customer service representatives.

Measure Year Two

Amerigroup demonstrated a statistically significant improvement over 1 measurement year for timeliness of postpartum care. The same prior year interventions were used.

Amerigroup demonstrated a statistically significant decrease for the CAHPS measure. The same prior year interventions were used.

PIP Topic	Measure Baseline	Measure 1	Measure 2
Timeliness of Postpartum Care	68.9%	76.9%	82.6%
CAHPS Measure-Customer Services at Child's Health Plan gave information needed.	84.3%	92.9%	70.5%

HSAG recommends continuing to document its QI processes annually and revisit the causal/barrier analysis processes through innovative quality strategies at least annually to ensure that identified and prioritized barriers to improvement are still relevant and that no new barriers requiring interventions exist and evaluate each intervention to determine effectiveness.

ITC PIP

Measure Year One

Iowa Total Care did not demonstrate a statistically significant improvement over 1 measurement year for timeliness of postpartum care. To improve this measure, the plan provided telephonic outreach to members to educate them on available incentives, sent automated text messages to those who may be pregnant based on claims and enrolled in Start Spart for Baby Program, shared gap in care reports with providers, and encouraged members to complete a notice of pregnancy which would assist the mother in securing a free breast pump. They also educated providers participating in their provider quality incentive program and attempted to gain remote access to electronic heath records to obtain the needed information but was not successful.

Iowa Total Care did not demonstrate a statistically significant improvement for the CAHPS measure. Interventions included improved communication methods for disseminating program materials, developed a guide for front-line agents to answer questions and routing questions to the pharmacy team, used after call surveys for more real time feedback. training for customer service representatives.

Measure Year Two

PIP Topic	Measure Baseline	Measure 1	Measure 2
Timeliness of Postpartum Care	72.5%	76.4%	77.9%
CAHPS Measure- Customer Services at Child's Health Plan gave information needed.	91%	94.4%	79.4%

HSAG recommends continuing to document its QI processes annually and revisit the causal/barrier analysis processes through innovative quality strategies at least annually to ensure that identified and prioritized barriers to improvement are still relevant and that no new barriers requiring interventions exist and evaluate each intervention to determine effectiveness.

NETWORK ADEQUACY

The state must include its network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs. Below are our network adequacy standards and links to the reports.

Managed Care Organizations

Primary Care Provider: The contract standard is having access within 30 minutes or miles from their personal residence for 100% of population.

Specialty Care: The contract standard is having access within 60 minutes or miles for 75% of population, and 90 minutes or miles for 99.5% of population from their personal residence.

Behavioral Health: The contract standard is having access within 30 minutes or miles, 60 minutes or miles for Urban counties, and 90 minutes or miles for Rural counties from their personal residence for 100% of population. Zip codes with population lesser than 1,000 per square mile are classified as Rural and zip codes with a population of 1,000 or higher per square mile are classified as Urban.

Hospital: The contract standard is having access within 30 minutes or miles from their personal residence for 99.5% of population.

Other Services: The contract standard is having access within 30 minutes or miles from their personal residence for 100% of population.

Our Network Adequacy reports can be found [Medicaid Performance and Reports | Health & Human Services (iowa.gov)] for current reports and [Medicaid Report Archive | Health & Human Services (iowa.gov)] for archived reports.

Dental Plans

All Providers: The contract standard is having access within 30 minutes or miles from their personal residence for 100% of population.

INTERMEDIATE SANCTIONS

HHS may impose sanctions due to noncompliance with contract requirements or applicable federal or State laws. Find our reports here [Medicaid Performance and Reports | Health & Human Services (iowa.gov)]. The types of intermediate sanctions shall be in accordance with §1932 of the Social Security Act (Title 42 of the United States Code §1396u-2) and 42 CFR §438.702-708, and may include:

- Civil monetary penalties in the amounts specified in 42 CFR §438.704.
- Appointment of temporary management for an MCO as provided in 42 CFR §438.706.
- Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.
- Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction.
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or HHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur in accordance with 42 CFR §438.730.
- Additional sanctions allowed under State statutes or regulations that address areas of noncompliance described above.

The areas of noncompliance that resulted in Liquidated Damages and Corrective Action Plan included:

- Approval timeline for Pharmacy PA's below threshold.
- Member/Provider Helpline Response below threshold.
- Non-compliance with Pharmacy PA CAP.
- Late or inaccurate reports.
- Encounter Data Submission.
- Develop a mechanism to ensure provider termination notices are provided to members within 30 calendar days prior to the effective date of the termination or 15 calendar days after the receipt or issuance of the termination notice.
- The MCO must ensure that it is collecting information related to member accessibility as indicated in the CMS Federal Register, as well as ensure that its online provider directory has the capability to display all collected data fields.
- The MCO must leverage technology to promote timely and effective communications with members.
- The MCO must collect information on a member's preferred mode of receipt of MCO generated communications and send materials in the selected format. Options must include, but are not limited to, the ability to receive paper communications via mail or electronic communications through a secure web portal.
- The MCO must provide members with the opportunity to review the care plan. The MCO must ensure that documentation clearly indicates that a copy of the care plan was provided to the member or whether the member was offered and declined. The MCO must integrate information about the members in order to facilitate positive member outcomes through care

coordination. The system must have the ability to share care coordination information with the member.

- The MCO must notify the requesting provider and give the member written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must include the service that is being denied.
- For a denial of payment, the MCO must mail the ABD notice at the time of any action affecting the claim. Additionally, for service authorization decisions not reached within the time frames specified in 42CFR, the MCO must deny the authorization and main and ABD to the member on the date that time frame expires.
- The MCO must ensure that members are accurately informed of the process for requesting disenrollment in accordance with DHS contract requirements.
- The MCO must ensure that members are informed of the disenrollment process, including that the member is to contact DHS to request disenrollment if the member remains dissatisfied at the conclusion of the MCO's grievance process.
- The MCO must ensure that the online provider directory has the capability to display information related to cultural competency at the facility/organizational level.
- The MCO must ensure that all access standards identified in the contract are also included in its policies and provider-facing materials.
- The MCO must complete initial credentialing applications within 45 days of receipt of the application.
- The MCO must ensure the practitioner has a valid DEA certification prior to the credentialing decision.
- The MCO must acknowledge receipt of each grievance within three business days.
- The MCO must fully review and resolve the grievance prior to closing the grievance and sending written resolution to the member.
- The MCO must ensure members can file an appeal orally or in writing. Additionally, the MCO must obtain written consent of the member for a provider or authorized representative to request an appeal on the behalf of the member.
- The MCO must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO must inform the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42CFR.

CMS Core Measures Review

Iowa Medicaid shares Core Measure results publicly [Microsoft Power BI (powerbigov.us)](powerbigov.us).

Back | Data Reference

STATE OF IOWA DEPARTMENT OF Health AND Human SERVICES

CMS CORE Set Measures - MCO & FFS

Published 3/27/2024

Adult/Child: All | Measure Category: All | Code: All

National Adult and Child Health Care Quality Measures are collected by the Centers for Medicare and Medicaid Services (CMS) on an annual basis with the results posted to the Medicaid.gov website. These measures are commonly referred to as Child Core Set Measures, Adult Core Set Measures, or simply CMS Core Set Measures if referring to both sets. Note: CMS links below that contain (*) link to charts that compare Iowa to all other states. All other links direct users to Iowa home page, uses must select "Quality of Care in Iowa". Green arrows indicate better than national average.

CMS CORE Set Measures & Links - Iowa measures are published on the CMS website

Measure Category	Code	FFY2020	FFY2021	FFY2022	Measure Name
Behavioral Health Care	IET-AD	↑	↑	↑	*Alcohol Abuse or Dependence: Age 18 and Older (Engagement Rate 34-days)
Behavioral Health Care	IET-AD	↓	↑	↑	*Alcohol Abuse or Dependence: Age 18 and Older (Initiation Rate 14-days)
Care of Acute and Chronic Conditions	AMB-CH	↑	↑	↑	*Ambulatory Care: Emergency Department (ED) Visits: Ages 0 to 19
Care of Acute and Chronic Conditions	AMR-CH	↓	↓	↓	*Asthma Medication Ratio: Ages 12 to 18
Care of Acute and Chronic Conditions	AMR-AD	↓	↓	↓	*Asthma Medication Ratio: Ages 19 to 50
Care of Acute and Chronic Conditions	AMR-AD	↓	↓	↓	*Asthma Medication Ratio: Ages 19 to 64 (Total)
Care of Acute and Chronic Conditions	AMR-CH	↓	↓	↓	*Asthma Medication Ratio: Ages 5 to 11
Care of Acute and Chronic Conditions	AMR-CH	↓	↓	↓	*Asthma Medication Ratio: Ages 5 to 18 (Total)
Care of Acute and Chronic Conditions	AMR-AD	↓	↓	↓	*Asthma Medication Ratio: Ages 51 to 64
Primary Care Access and Preventive Care	BCS-AD	↑	↑	↑	*Breast Cancer Screening: Ages 50 to 74

Directed Payments

Currently Iowa has four directed payments established which meet the definition above. Ground Emergency Medical Transportation, a Physician Directed Payment with the University of Iowa, a Hospital ACR Directed Payment with the University of Iowa, and an all-hospital directed payment which is funded by provider assessment tax. [Approved State Directed Payment Preprints | Medicaid]

Directed Payment	Measure	Quality Strategy Goal
GEMT	% of transports that did not result in an admission	Access to Care
GEMT	% of ambulance trips that resulted in treatment but no transport	Decrease Cost of Care
All Hospital	Follow-Up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD)	Access to Care
All Hospital	All-Cause Readmissions; NQF 1789	Decrease Cost of Care
All Hospital	Primary cesarean delivery rate uncomplicated; IQ133	Access to Care, Health Equity
U of I Hospital	Access to care encounters – Outpatient In-Person Office Visits	Access to Care
U of I Hospital	Access to care encounters – Telehealth Visits	Access to Care
U of I Hospital	Access to care encounters – Inpatient Encounters	Access to Care
U of I Hospital	Access to care encounters – Emergency Department Encounters	Access to Care
U of I Hospital	Mental Health – Outpatient Encounters	Behavioral Health, Access to Care
U of I Hospital	Mental Health – Inpatient Discharges	Behavioral Health
U of I Hospital	Maternal Health – Outpatient Encounters	Behavioral Health
U of I Hospital	Maternal Health – Inpatient Encounters	Behavioral Health
U of I Hospital	Maternal Health – High Blood Pressure	Improving Coordinated Care, Access to Care
U of I Physician	Access to care encounters – Outpatient In-Person Office Visits	Access to Care
U of I Physician	Access to care encounters – Telehealth Visits	Access to Care
U of I Physician	Access to care encounters – Inpatient Encounters	Access to Care
U of I Physician	Access to care encounters – Emergency Department Encounters	Access to Care
U of I Physician	Follow-Up After Emergency Department Visit for Mental Illness - 30 day	Behavioral Health, Access to Care
U of I Physician	Follow-Up After Emergency Department Visit for Mental Illness - 7 day	Behavioral Health, Access to Care
U of I Physician	Follow-Up After Hospitalization for Mental Illness: Ages 21+: 30-day	Behavioral Health, Access to Care
U of I Physician	Follow-Up After Hospitalization for Mental Illness: Ages 21+: 7-day	Behavioral Health, Access to Care
U of I Physician	Follow-Up After Hospitalization for Mental Illness: Ages 21+: 7-day	Behavioral Health, Access to Care
U of I Physician	Follow-Up After Hospitalization for Mental Illness: Ages 6 – 20: 7-day	Behavioral Health, Access to Care

U of I Physician	Postpartum Follow-up and Care Coordination	Access to Care, Health Equity
U of I Physician	Postpartum Follow-up and Care Coordination	Access to Care, Health Equity
U of I Physician	Integrated 5 P's SUD Screening Tool	Behavioral Health, Health Equity

LTSS Quality Measures

Currently Iowa has seven waivers and Habilitation State Plan Services. Home and Community-Based Services (HCBS) Waivers Program | Health & Human Services (iowa.gov).

- Aids/HIV
- Brain Injury
- Children's Mental Health
- Elderly
- Health and Disability
- Intellectual Disability
- Physical Disability
- Habilitation State Plan Services

Measure	Numerator	Denominator
Number and percent of required MCO HCBS PM quarterly reports that are submitted timely	# of required MCO HCBS PM quarterly reports submitted timely	# of MCO HCBS PM quarterly reports due in a calendar quarter.
Number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures. Numerator	# of months each MCO entered all required HCBS PM data	# of reportable HCBS PM months in a calendar quarter.
Number and percent of referrals for LOC that received a completed LOC decision.	# of referrals for LOC that received a completed LOC decision	# of referrals for LOC.
Number and percent of initial level of care decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures.	# of initial LOC decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures	# of reviewed initial LOC determinations
Number and percent of newly enrolled waiver providers verified against the appropriate licensing or certification	#of newly enrolled waiver providers verified against appropriate licensing or certification standards prior to furnishing services	# of newly enrolled waiver providers required to be licensed or certified

standards prior to furnishing services.		
Number and percent of licensed/certified waiver provider re-enrollments verified against the appropriate licensing/certification standards prior to continuing to furnish services.	# of licensed/certified waiver provider re-enrollments verified against the appropriate licensing/certification standards prior to continuing to furnish services	# of licensed/certified waiver provider re-enrollments.
Number and percent of non-licensed/noncertified providers that met waiver requirements prior to direct service delivery.	# of non-licensed/noncertified providers who met waiver requirements prior to direct service delivery	# of non-licensed/noncertified providers.
Number and percent of Consumer Choice Option (CCO) providers that met waiver requirements prior to direct service delivery.	# of CCO providers who met waiver requirements prior to direct service delivery	# of CCO providers
Number and percent of HCBS providers that meet training requirements as outlined in State regulations and the approved waiver	# of HCBS providers that meet training requirements as outlined in State regulations and the approved waiver	# of HCBS providers that had a certification or periodic quality assurance review.
Number and percent of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals	# of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals	# of reviewed service plans
Number and percent of members who responded "YES" on the HCBS IPES survey to the question "IF YOUR NEEDS HAVE CHANGED, DID YOUR SERVICES CHANGE TO MEET THOSE NEEDS?".	# of members who responded "YES" on the HCS IPES survey to the question "IF YOUR NEEDS HAVE CHANGED, DID YOUR SERVICES CHANGE TO MEET THOSE NEEDS?"	Total # of members who answered the question "IF YOUR NEEDS HAVE CHANGED, DID YOUR SERVICES CHANGE TO MEET THOSE NEEDS?" on the HCBS IPES survey.

Number and percent of service plans which are updated on or before the member's annual due date.	# of service plans which were updated on or before the member's annual due date	# service plans due for annual update that were reviewed
Number and percent of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan.	# of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan.	# of member's service plans reviewed
Number and percent of HCBS IPES respondents who responded that they had a choice of services.	# of HCBS IPES respondents who responded that they had a choice of services	# of HCBS IPES respondents that answered the question asking if they had a choice of services.
Number and percent of service plans from the HCBS QA survey review that indicated the member had a choice of HCBS service providers	# of service plans from the HCBS QA survey review that indicated the member had a choice of HCBS service providers	# of service plans from the HCBS QA survey that were reviewed
Number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated as required.	# IAC-defined major critical incidents requiring follow-up escalation that were investigated as required	# of IAC-defined major critical incidents requiring follow-up escalation
Number and percent of Critical Incident Reports (CIRs) including alleged abuse, neglect, exploitation, or unexplained death that were followed up on as required.	# of CIRs including alleged abuse, neglect, exploitation, or unexplained death that were followed up on as required	# of CIRs that included alleged abuse, neglect, exploitation, or unexplained death.
Number and percent of member service plans that indicate the member received information on how to identify and report abuse, neglect, exploitation, and unexplained deaths	# of members service plans that indicate the members received information on how to identify and report abuse, neglect, exploitation, and unexplained deaths	Total # of member service plans reviewed.

Number and percent of unresolved critical incidents that resulted in a targeted review that were appropriately resolved.	# of unresolved critical incidents that resulted in a targeted review that were appropriately resolved	# of unresolved critical incidents that resulted in a targeted review.
Number and percent of critical incidents where root cause was identified.	# of critical incidents where root cause was identified.	# of Critical Incident Reports
Number and percent of providers that met the requirements for the use of restraint, restriction, or behavioral intervention programs with restrictive procedures.	Number and percent of providers that met the requirements for the use of restraint, restriction, or behavioral intervention programs with restrictive procedures.	Number and percent of providers that met the requirements for the use of restraint, restriction, or behavioral intervention programs with restrictive procedures.
Number and percent of waiver members who received care from a primary care physician in the last 12 months.	# of waiver members who received care from a primary care physician in the last 12 months	# of waiver members reviewed.
Total # of reviewed paid claims	Total # of reviewed paid claims	Total # of reviewed paid claims
Number and percent of clean claims that are paid by the managed care organizations within the timeframes specified in the contract.	# of clean claims that are paid by the managed care organization within the timeframes specified in the contract	# of Managed Care provider claims.
Number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided.	# of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided	# of paid claims
Number and percent of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology.	# of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology	# of capitation payments to the MCO's.

HSAG Recommendations

The EQR report includes recommendations for improving the quality of health care services furnished by each MCO and PAHP entity. It includes how HHS can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. HHS ensures updates to the quality strategy take into consideration the recommendations provided by an EQR and describes how updates to the quality strategy take those recommendations into consideration. The EQR technical report also includes recommendations on how HHS can target quality strategy goals and objectives in order to support improvements in quality of care.

EQRO TECHNICAL REPORT APRIL 2023

HSAG recommends that HHS revise its Quality Strategy to include all programs supported by the MCOs and PAHPs. HHS could develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal. Each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound). HHS could present the Quality Strategy goals and performance objectives in a table format that also identifies whether each goal and objective apply to the MCOs, PAHPs, or both. Additionally, while HHS' contract with the PAHPs requires the PAHPs to deliver services to all members in a culturally competent manner, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity, it did not include any specific provisions addressing health equity in dental care. HHS could consider strengthening contract language to address health equity; for example, requiring the PAHPs to conduct an assessment of existing health disparities, including disparities identified through the results of performance measure reporting, and develop a formal health equity plan. HHS could also consider applying the MCO NAV activity methodology to the PAHP NAV activity and stratify PAHP results by race/ethnicity, urbanicity, age, and a concentrated disadvantage index.

EQRO TECHNICAL REPORT APRIL 2024

Additionally, HHS' existing MCO Quality Strategy does not include measurable performance metrics for most goals. HHS should establish minimum performance standards or performance thresholds for each access and coordinated care-related goal and objective. Establishing a statewide performance benchmark will assist HHS in quantitatively evaluating the Iowa Managed Care Program's progress in meeting HHS' established MCO Quality Strategy goals and objectives.

HHS could consider providing the PAHPs with the case-level data files and a timeline for each PAHP to address discrepancies identified during the secret shopper survey calls (e.g., incorrect, or disconnected telephone numbers and addresses, PAHP and Iowa Medicaid acceptance, new patient acceptance, and/or provider specialty information).

HHS should require the PAHPs to conduct a root cause analysis to identify the cause for the data discrepancies, and HHS should consider requiring the PAHPs to conduct a review of the offices' eligibility verification requirements to ensure that any barriers identified do not hinder members' ability to access dental care.

HHS should require its PAHPs and its MCOs to conduct routine secret shopper surveys of their provider networks to assess compliance with network adequacy and appointment availability standards.

HHS should require calculation of the mandatory CMS Core Set measures by MCO. HHS could accomplish this by requiring its MCOs to calculate and report on each mandatory Core Set measure or contract with its existing vendor to calculate each mandatory Core Set measure by MCO, in addition to calculating the statewide aggregate rates for each measure.

CMS Feedback to Quality Strategy 2021 (MCO)

MANAGED CARE AND GOALS, OBJECTIVES, AND OVERVIEW

42 CFR 438.340(b)(2) and 457.1240(e)
The state must identify goals and objectives for continuous quality improvement.

These goals and objectives must be measurable and take into consideration the health status of all populations in the state served by the managed care organization (MCO), prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP).

Although the state includes a section on goals on pages 6 - 7, it is unclear which parts of this section are goals and which are objectives. The state may find it helpful to review Chapter 2, Section D (pages 12 - 14) of the Quality Strategy Toolkit.

We agree with this assessment and are working internally to create a dashboard that outlines goals, objectives, measures, drivers, and activities. This will be reflected in our 2024 Quality Strategy Update.

QUALITY AND APPROPRIATENESS OF CARE

42 CFR 438.340(b)(3)(i) and 457.1240(e), cross-referencing 438.330(c)(1)(i) The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, or PAHP with which it contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c). Although the state indicates on page 14 that plans report Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, the state does not include the specific quality metrics it uses to measure plan performance and improvement. In addition, although the state describes pay for performance measures, it does not include performance targets for these metrics.
The state may find it helpful to review Chapter 2, Section E.1 (pages 15 - 17) of the Quality Strategy Toolkit.
We agree with this assessment and are working internally to create a dashboard that outlines all of the measures (including performance measures) that includes performance targets for these metrics. During COVID the Benchmarks were removed.

42 CFR 438.340(b)(3)(i) and 457.1240(e), cross-referencing 438.330(c)(1)(ii) If the state contracts with MCOs, PIHPs, and/or PAHPs to provide long-term services and supports (LTSS), the state must describe in its quality strategy the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving LTSS.
Although the state includes one performance measure that it uses for individuals receiving LTSS on page 15, it is unclear whether the state uses other performance measures to address quality of life, rebalancing, and community integration activities for individuals receiving LTSS.
The state may find it helpful to review Chapter, Section E.3 (pages 19 - 20) of the Quality Strategy Toolkit.
We agree with this assessment and are working internally to create a dashboard that outlines performance measures to address quality of life, rebalancing, and community integration activities for individuals receiving LTSS.

42 CFR 438.340(b)(6) and 457.1240(e) The state must include its plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The state describes three ways in which it addresses health disparities on page 23: (1) collection and use of age, race, ethnicity, and gender data, (2) collection and use of health risk assessment data, and (3) health equity plans. However, it is unclear whether these initiatives address disparities based on primary language and disability status.

The state may find it helpful to review Chapter 2, Section E.6 (pages 22 - 23) of the Quality Strategy Toolkit. We agree with this assessment. We are in the first phase of this work which is developing Health Equity Plans at the MCO and Medicaid level. These initiatives include a plan to address disparities based on primary language and disability status.

MONITORING AND COMPLIANCE

42 CFR 438.340(b)(1) and 457.1240(e). The state must detail its network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206.
The state indicates on page 7 that its access standards are outlined in its plan contracts, and the state links to a website containing these contracts. However, the state's link contains numerous contracts and contract amendments, and it is unclear which specific documents readers should review to find the state's current standards.
The state may find it helpful to review Chapter 2, Section F.1 (page 24) of the Quality Strategy Toolkit.

42 CFR 438.340(b)(1) and 457.1240(e) The state must provide examples of evidence-based clinical practice. Although the state includes a section titled "evidence-based practices" on page 20, it is unclear what specific clinical practice guidelines, if any, the state requires plans to use.
The state may find it helpful to review Chapter 2, Section F.2 (page 25) of the Quality Strategy Toolkit.

42 CFR 438.340(b)(7) and 457.1240(e) The state must include, for MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of Subpart I. The state does not appear to describe appropriate use of intermediate sanctions that meet the requirements of Subpart I. The state may find it helpful to review Chapter 2, Section F.3 (page 25) of the Quality Strategy Toolkit.

EXTERNAL QUALITY REVIEW (EQR) ARRANGEMENTS

42 CFR 438.340(b)(9) and 457.1240(e), cross-referencing 438.360(c) If the state utilizes the non-duplication option in 42 CFR 438.360 for EQR, it must identify the EQR-related activities for which it has exercised the option. It is unclear whether the state uses the non-duplication option, and if so, the EQR-related activities for which it has exercised the option. The state may find it helpful to review Chapter 2, Section G.2 (page 26 - 27) of the Quality Strategy Toolkit.

42 CFR 438.340(b)(9) and 457.1240(e), cross-referencing 438.360(c) If the state utilizes the non-duplication option in 42 CFR 438.360 for EQR, it must explain the rationale for its determination that the Medicare review or private accreditation activity is comparable to such EQR-related activities. It is unclear whether the state use the non-duplication option, and if so, the rationale for its determination that the Medicare review or private accreditation activity is comparable to such EQR-related activities. The state may find it helpful to review Chapter 2, Section G.2 (page 26 - 27) of the Quality Strategy Toolkit.

CMS Feedback to Quality Strategy 2023 (PHAP)

QUALITY STRATEGY REVIEW AND SUBMISSION ELEMENTS

42 CFR 438.340(b)(10) and 457.1240(e)
The state must include its definition of a "significant change" for the purposes of revising the quality strategy per 42 CFR 438.340(c)(3)(ii).

Although the state mentioned "significant change" in the quality strategy (QS), it did not define it (page 4). To comply with this requirement, the state can define a significant change. For example, a significant change may be "any change to the state's Medicaid or CHIP program" or "change to the state's managed care program." For more information on how the state can meet this requirement, the state may find it helpful to review Chapter 3, Section A (pages 28 – 29) of the Quality Strategy Toolkit.

The state will update to define significant change.

42 CFR 438.340(c)(1)(i) and 457.1240(e)
The state must make the quality strategy available for public comment before submitting it to CMS for review, including obtaining input from the Medical Care Advisory Committee, beneficiaries, and other stakeholders.

Although the state mentioned that it obtained feedback from its Medicaid Clinical Advisory Committee (page 12), it is unclear whether this organization is the same as the Medical Care Advisory Committee (MCAC). Additionally, while the state referenced documents and resources from the Medicaid Clinical Advisory Committee and noted that it worked to obtain information from the Committee on policies that impact health quality outcomes, it is unclear if the Medicaid Clinical Advisory Committee was provided a draft of the QS for comment. To comply with this requirement, the state can clarify whether (1) the Medicaid Clinical Advisory Committee is the same as the MCAC and (2) the MCAC reviewed and provided input on the state's QS. We also encourage the state, if applicable, to share any feedback from the MCAC and how the feedback was incorporated into the QS. The state may find it helpful to review Chapter 4, Section A (pages 32 – 33) of the Quality Strategy Toolkit.

This can be corrected. We did present to MAAC and ensure it is the same throughout. No feedback was provided by the MAAC.

42 CFR 438.340(c)(2)(i), 438.340(c)(2)(ii), and 457.1240(e)
The state must review and update its quality strategy as needed, but no less than once every three years. This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years. The results of the review must be available on the state's website.

The state did not indicate whether it evaluated the effectiveness of its QS within the previous three years, nor was CMS able to identify results from this evaluation on its website.
To comply with this requirement, the state can indicate whether it evaluated the effectiveness of its QS, and if so, provide a summary of its evaluation process and findings either within the QS or via a link to its website where the evaluation findings are posted. We also encourage the state to describe how the effectiveness evaluation of its 2023 QS impacted updates to the revised QS. For example, if the effectiveness evaluation led to changes in its goals and objectives, the state can note that when discussing the QS evaluation findings.

While one was not completed prior to updating this specific QS, we are currently in the process of evaluating both current quality strategies with the goal to combine them with one updated quality strategy for July 1, 2024.

42 CFR 438.340(c)(2)(iii) and 457.1240(e)
The state must discuss how updates to the quality strategy take into consideration the recommendations provided by an External Quality Review Organization (EQRO) pursuant to 42 CFR 438.364(a)(4).

The state did not describe how updates to the QS take into consideration the recommendations provided by an EQRO. In the state's 2022 external quality review technical (EQR) report, the state's EQRO recommended that the state consider developing a comprehensive QS that integrates all the state's managed care programs, including its managed care organizations and prepaid ambulatory health plans. CMS would appreciate if the state can share its reasoning for not adopting this recommendation. To comply with this requirement, the state can link to its 2023 EQR report in the next revision of its QS and highlight specific report sections that provide recommendations. Alternatively, the state can note directly in its QS how it considered the recommendations provided by the EQRO.
The state may find it helpful to review Chapter 3, Section B.2 (page 31) of the Quality Strategy Toolkit.

The state will link to its 2023 EQR report in the next revision of our QS and highlight specific report sections that provide recommendations. Alternatively, the state can note directly in its QS how it considered the recommendations provided by the EQRO.

QUALITY MEASUREMENT AND IMPROVEMENT

42 CFR 438.340(b)(3)(i) and 457.1240(e)
The state must identify which quality measures and performance outcomes it will publish at least annually on its web site. Although the state submitted a separate document that includes its dental quality metrics and performance outcomes and noted on pages 12 – 13 that a Quality Measures Dashboard is expected to be live in July 2023, it does not appear to indicate which of the dental metrics in the QS will be published at least annually or provide a working link to its dashboard.
To comply with this requirement, the state can indicate in its revised QS which dental metrics it will publish annually or provide a working link to its dashboard.
For more information on how the state can meet this requirement, the state may find it helpful to review Chapter 2, Section E.2 (page 18) of the Quality Strategy Toolkit.

Our Medical and Dental Dashboard is located here Microsoft Power BI (powerbigov.us).

42 CFR 438.340(b)(6) and 457.1240(e)
The state must include its plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.
The state must include its definition of "disability status" in its disparity plan indicate how it will make the determination that a Medicaid beneficiary meets its definition of disability status and indicate the data sources it will use to identify disability status. determine disability status, the state can clarify this in the quality strategy.
Finally, we thank the state for providing details on data metrics it will use to monitor disparities and those it considered for its PAHP Health Equity Plan. The state indicated that its SFY 2023 dental PAHPs contracts will require the managed care plans (MCPs) to provide a plan for addressing equity issues. We look forward to learning more about these plans in the next revision of the QS.
For more information on how the state can meet this requirement, the state may find it helpful to review Chapter 2, Section E.6 (pages 22 - 23) of the Quality Strategy Toolkit.

Dental disability rate cells are defined by eligibility using the following ELIAS Coverage Group descriptions in our dashboard Microsoft Power BI (powerbigov.us).

Here's What We Found

HHS Quality Strategy 2024 requires an update that is more aligned through overarching goals with SMART goals, combining the MCO and PAHP Quality Strategies.

Goals

EQR recommended that both the Quality Strategies be combined with aligned strategic priorities and goals. Below is a table that identifies current alignment to inform the 2024 Quality Strategy.

Strategic Goal	MCO	PAHP
Behavioral Health	Behavioral Health	None
Access	Access to Care	Network Adequacy and Availability of Services
Program Administration	Program Administration	Program Administration
Decrease Cost of Care	Decrease Cost of Care	Decrease Cost of Care
Improving Coordinated Care	Improving Coordinated Care	Increase Recall and Prevention Services Improving Coordinated Care
Continuity of Care	Continuity of Care	Continuity of Care between MCPs
Health Equity	Health Equity	Improving Oral Health Equity
Voice of the Customer	Voice of the Customer	None

MCO

Behavioral Health

Our goal was to improve behavioral health but did not set specific benchmarks and goals for improvement. Much of the three years Managed Care P4P for FUH and FUM measures were leveraged as well as HSAG Network Adequacy Validation Study, Integrated Health Home Workgroups to identify program improvements, incorporated behavioral health in our directed payments and the managed care health equity plans, and more recently was awarded a demonstration grant to implement CCBHCs to focus on BH and SUD.

- Managed Care Pay for Performance Measures have been successful at improving follow-up after hospitalizations and ED visits.
- Managed Care Health Equity Plans focused on BH and SUD noting a disparity in Black and Latinx members, more specifically related to depression medication adherence, and follow-up after hospitalization. Amerigroup is focused on improving their case management dashboard, increased housing initiatives, built reginal provider and community relationships and partnerships, and included value added benefits to support members with a BH and SUD diagnosis. Iowa Total Care is focused on provider training for Follow-up after Hospitalization, provider summit that addresses SDOH and Health Equity, expand community health workers, post discharge text campaigns.
- HSAG Behavioral Health Network Adequacy: monitor for any barriers that may impede a new pediatric member from receiving behavioral health services.
- Integrated Health Home Workgroup: Update the tiering and payment system to be more reflective of the population risk and reduce provider burden, change the eligibility criteria to allow more ways a member can qualify, expand the care coordinator requirements to address workforce issues.
- Iowa Total Care QM Improvement Plan 2023.

  - Identified Access issues through data in the outpatient space and through appeals. Members felt that they were not informed about treatment options or managing their conditions.
  - Identified the need to improve medication monitoring.
  - The top SDOH issues where housing, transportation, and health literacy.
  - Top diagnosis: anxiety, major depression disorder, ADHD, and PTSD.
  - They noted a high suicide and have a program called choose tomorrow.
  - Other programs: Bridge to care project, Halo Program for SUD, and implement an SUD Toolkit.
- Amerigroup now Wellpoint QM Plan
  - The plan did not provide clear identifications of areas of improvement and goals, but goals were primarily quality assurance goals in order to meet standards.
- Directed Payments
  - U of I Hospital expanded the CoCM model and hired additional mental health providers. They also hired crisis safety officers as well as a training program. They partnered to expedite a pathway for those that do not have guardians and collaborate with MHDS to support community-based system of care.
  - U of I Physician introduced care coordinators for transitions in care activities.

Access

Because we didn't have SMART goals with specific measures and benchmarks, it was difficult to determine if goals were met. There was a focus on better identifying access to behavioral health through network adequacy review. Work with our GEMT Directed payment, while not effective at impacting access, future goals will be directed towards access to care.

- Increasing covered lives in value-based purchasing arrangements at a minimum of 40%
  - Discuss with the Quality Committee if we want this in a specific area such as prenatal and postnatal care or behavioral or dental.
- Improve network adequacy.
  - Dental and BH focus.
  - Network adequacy standards to include minimum required provider-to-member ratios for PCPs, specialists, and dentists.
  - Disruption analysis in future NAV activities. A disruption analysis may provide valuable information on whether members retained access to their PCPs, and whether provider networks and time/distance access standards were impacted.
- Improve timeliness of Postpartum Care: Primary Cesarean Rate. Primary Cesarean Rates is not a metric we chose to continue.
  - Maternal Health Social Drivers: Transportation and food insecurities. In our Health Risk Assessments, we identified food insecurities and transportation issues. We have implemented Mom's Meals as a pilot program as well as transportation to get food and other things they need.
  - Expanding Medicaid to 12 months postpartum.
  - Assessing Managed Care Postpartum Case Management to ensure access to coordinated care (includes HRA pre- and post-partum) to identify SDOH, mental health and substance use disorder needs.
  - Focus on maternal morbidity and mortality reduction.
- Increase access to primary care and specialty care: GEMT, Primary Care.
- Add a provision to the contract requiring the MCOs to engage in two additional PIPs per year (e.g., two HSAG validated PIPs and two non-HSAG validated PIPs). Prevention and care of acute and chronic conditions, high-risk services, oral health, etc. for SFY2026.
- MPSs or performance thresholds for a select number of HEDIS performance measures which align with HHS' Quality Strategy goals for SFY2026.
- Consider requiring its MCPs to conduct routine secret shopper surveys of their provider networks to assess compliance with network adequacy and appointment availability standards.

Program Administration

Because we didn't have SMART goals with specific measures and benchmarks, it was difficult to determine if goals were met. The MCOs did meet thresholds for timely claims reprocessing and encounter data reporting. Opportunities for improvement are around ensuring grievances, appeals, and exception to policy processes meet state and federal requirements as well as identify opportunities for improvement.

Decrease Cost of Care

Our goal was to meet "Reducing the rate of potentially Preventable readmissions" and "Non-emergent ED visits". We remained steady and are below the median of reported states. Work needs to be facilitated with each Bureau to identify areas of opportunity to reduce the cost of care.

Improving Coordinated Care

Health Risk Assessments met the goal for completion. This benchmark needs to be refined and a potential new goal created. PIP projects.
Prenatal timeliness continues to be lower than the national average. (Health Equity, Maternal Health Task Force and Iowa Maternal Quality Care Collaborative)
Postpartum Visit Rate

- Transportation to get food. Project started to provide transportation for doctor's appointments, food etc.
- Increase case management postpartum.
- Expanding Medicaid to 12 months postpartum.

Focus on "Timeliness of Prenatal Care" rate under the Prenatal and Postpartum Care performance measure ranked below the 25th percentile, indicating that many pregnant women receiving services under the Iowa Managed Care Program did not receive a timely prenatal care visit within the first trimester. Prenatal care is critical in ensuring healthy outcomes for new mothers and their babies, including a healthy birth weight.

Community Integration Management is a new program and work may need to occur for improvement.

B3 services
HHS is requiring the MCOs to complete an LTSS Project as a Pay for Performance measure. This project requires them to address causes for members not receiving needed services and timeliness for needed services. We allow exceptions for timelines and expect the MCOs to reduce the number of exceptions with the goal to improve timeliness to service. This project includes community education. The draft plan is required September of 2024 with implementation June 30, 2025.

Changing the ride along oversight to be a statistically significant sample and will include additional questions to ensure restrictive interventions and core elements have been identified.

Continuity of Care

The Quality Committee needs to consider measuring, creating benchmarks for the following areas as it relates to continuity of care:

- Assessment
- Person-centered care planning
  - Member's choice and/or placement in alternative HCBS settings.
  - Address transitions to another setting
  - Discharge planning
- Residential settings
- Incident reporting
- Survey questions that relate to continuity of care

Health Equity

It is not clear if a reduction in disparities occurred in the areas addressed in their original Health Equity Plan. The MCOs did identify an increase in staff training, collaboration in the community, increase in programs to address issues, and provided success stories that described their work. The Quality Committee should provide additional feedback and direction to the MCPs around Health Equity. Dental has been siloed and not included in this goal.

- In SFY 2026 P4P for both PAHPs and MCOs should include Health Equity as a project as we have not included the newest MCO nor the PAHPs in this exercise.
- Include oversight that requires a clear reporting of reduction in disparities in the identified areas.
- Identify disparities across the Medicaid membership to identify recommendations for areas of focus for the MCPs.
- Apply the MCO NAV activity methodology to the PAHP NAV activity and stratify PAHP results by race/ethnicity, urbanicity, age, and a concentrated disadvantage index.

Voice of the Customer

SMART goals were not identified for the voice of the customer. While some years MCOs scored higher than the national average, some questions have dropped in the recent year.

- Specialist Seen Most Often has declined suggests that some members may have been deterred from going to their specialists for care based on their negative personal experiences.
- Discussing Cessation Medications for the adult population
- Rating of All Health Care for the child population.
- Customer Service at Child's Health Plan

The updated Quality Strategy should include:

- Use the national average as a benchmark for CAHPS survey questions.
- Identify CAHPS survey questions that align with other goals within the Quality Strategy.
- Use the quality framework to review MCP practices for grievance and appeals ensuring they meet state and federal requirements, then identifying areas for improvement to increase member satisfaction when concerns are identified.

Current Medicaid Projects

Medicaid has several projects in different stages. These projects need to be included in the updated Quality Strategy. More can be found about them here.

- American Recue Plan (ARPA)
- COVID-19 Unwind
- Electronic Visit Verification (EVV)
- Hope and Opportunity in Many Environments (HOME)
- Medicaid Enterprise Modernization Effort (MEME)
- Therapeutic Foster Care Pilot (TFC)