Iowa HHS Medicaid Quality Strategy

July 2024

IOWA | Health and Human Services

IOWA | Health and Human Services

Table of Contents

Iowa HHS Medicaid Quality Strategy

INTRODUCTION

Overview of Managed Care

Iowa HHS Medicaid contracts with Managed Care Plans (MCPs) to provide comprehensive health care services including dental, PACE, physical health, behavioral health (mental health and substance use disorders), and long-term services and supports (LTSS) to Iowans enrolled in Medicaid.

Iowa's Medicaid Quality Strategy is Iowa Medicaid's guidance document to oversee Iowa's Medicaid MCPs and to explore possibilities of utilizing clinical outcome-based research in the development of a set of measures to complement existing systems.

The Iowa Managed Care Plan contracts are procured through a competitive bidding process. Contractually the MCPs are held responsible for addressing quality of care related problems at both the programmatic and individual provider level. The contracts contain requirements that are based on quality initiatives and measurements, are specifically designed to support the goals listed in the quality plan.

Performance monitoring and data analysis are critical components in assessing how well the MCPs are maintaining and improving the quality of care delivered to members. Multiple oversight tools are deployed in this effort. The Department develops and publishes a Medicaid Managed Care Performance Report quarterly, as well as annually. The MCO Performance Reports are posted to the HHS website: Medicaid Performance and Reports | Health & Human Services (iowa.gov)

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.

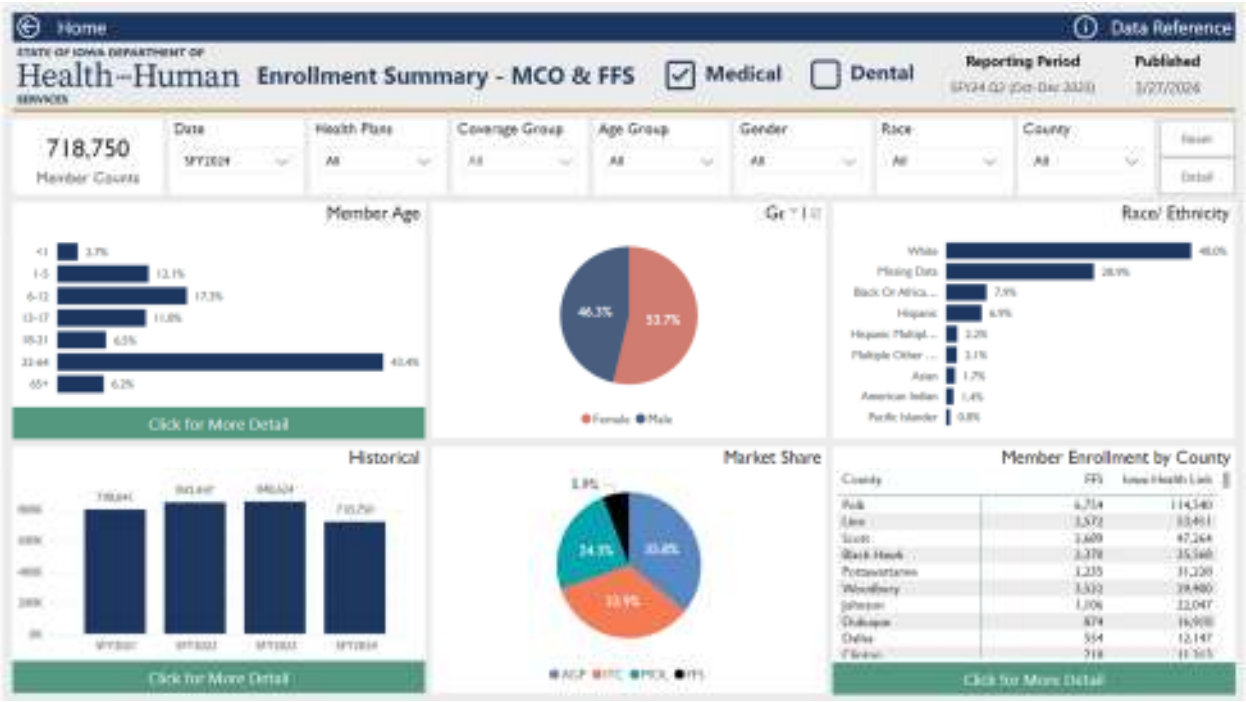
Plans	Type	Services	Abbreviations	Populations
Amerigroup/ Wellpoint	MCO	Behavioral and Physical	AGP/WLP	All members are eligible including CHIP
Iowa Total Care	MCO	Behavioral and Physical	ITC	All members are eligible including CHIP
Molina Healthcare	MCO	Behavioral and Physical	MOL	All members are eligible 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+

Managed Care Plan Enrollment Summary

Medicaid has a dashboard that is updated quarterly with enrollment data. For more information: [Microsoft Power BI (powerbigov.us)]

Managed Care Organizations



Pre-Paid Ambulatory Health Plans

Program of All-Inclusive Care for the Elderly

Iowa Managed Care History

Managed Care Organizations (MCOs)

The Iowa Medicaid is a division of Iowa Health and Human Services (HHS). In 2016, nearly all Iowa Medicaid members, including members receiving long-term services and supports (LTSS), were transitioned to the Iowa Health Link program, and began receiving benefits through contracted MCOs. The state maintains a small Fee for Service (FFS) population that accounts for 6% outlined below:

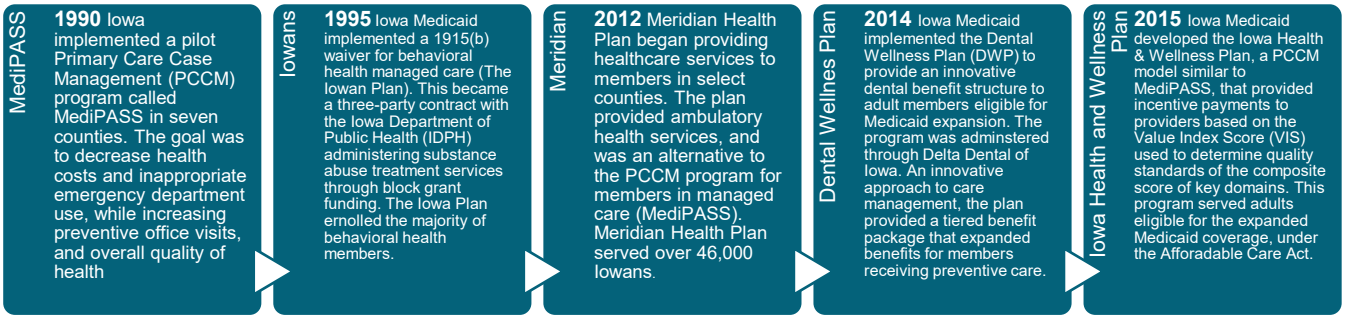
- Health Insurance Premium Payment Program (HIPP)
- Medicare Savings Program (MSP)
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Three Day Emergency
- Medically Needed (Spenddown Program)
- Presumptive Eligible (PE)
- American Indian or Alaska Native Program

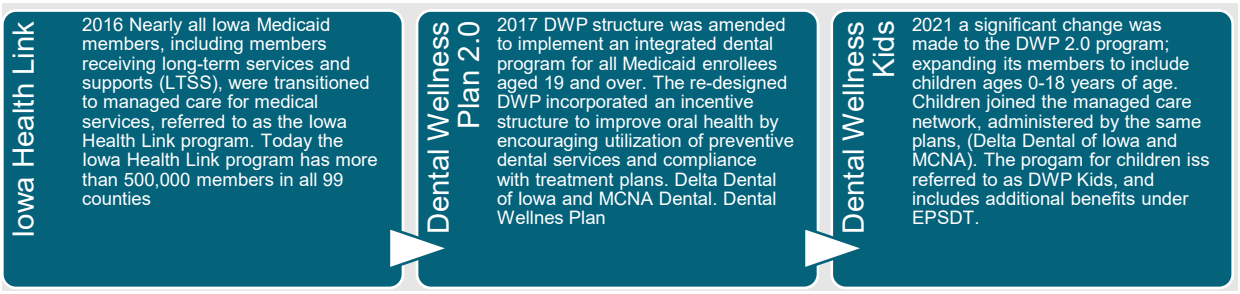
Populations served by Managed Care Organizations:

- Children's Health Insurance Program (CHIP)
- Healthy and Well Kids in Iowa (Hawki)
- Iowa Health and Wellness (IHAWP)
- Iowa Health Link

For the most up to date demographics: [Microsoft Power BI (powerbigov.us)]

Pre-Paid Ambulatory Health Plans (PHAPs)





MISSION, VISION, AND VALUES

Iowa Medicaid is committed to ensuring at all members have equitable access to high quality services that promote dignity, removing barriers to increase member health engagement, and improving whole person health across populations.

Mission

Iowa Medicaid is committed to ensuring that – all members have equitable access to high quality services that promote dignity, barriers are removed to increase health engagement, and whole person health is improved across populations.

Vision

Iowa Medicaid works diligently to operate a fiscally responsible and sustainable program that improves the lives of its members through effective internal and external collaboration, innovative solutions to identified challenges, and data driven program improvement.

Values

Partnership

We are dedicated to building relationships amongst internal team members as well as with community stakeholders to improve communication patterns, building trust through transparency, and fuel the ability to create meaningful change. Partnerships also assist in maximizing resources through shared responsibility and workload.

Integrity

Honesty, transparency, and consistent application of the organizational value structure builds trust with the Iowans we serve. The Medicaid program learns from mistakes, is committed to following through with commitments, and communicates openly about concerns.

Diversity, Equity, And Inclusion (DEI)

Medicaid, by design, is a safety net program that assists individuals in overcoming barriers to healthcare. Focusing on the populations and geographic areas where healthcare is accessed at lower levels is as important as focusing on where it is successful. It is critical to promote solutions that align with the value of DEI and bring a broad base of stakeholder input to the table, including those with lived experience.

Accountability

Accountability to communicate concerns, articulate expectations, identify solutions, and timely resolution is multidirectional and valued by all engaged. The Medicaid team has ownership in in the strategic plan and creating successful outcomes for the program.

Advocacy

The Medicaid program is committed to advocating for our taxpayers, recipients, healthcare providers, staff, and other stakeholders in all that we do. As a team, we bring our voices to the table in determining solutions that have the greatest impact to all and engage partners to do the same.

SIGNIFICANT CHANGE

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 members.

REVISION PROCESS FOR THE QUALITY STRATEGY

The Medicaid Quality Strategy undergoes a formal review by the Iowa Medicaid Quality Committee no less than once every three years. The Quality Committee also reviews and approves or denies any updates or changes to the Quality Strategy as needed. As part of the Quality Committee’s formal review of the Medicaid Quality Strategy once every three years, the Quality Committee also conducts a formal evaluation of the effectiveness of the Quality Strategy over those previous three years. The results of the Quality Committee’s formal review and evaluation is documented and posted on the website once CMS review is completed. The Quality Committee’s formal review and evaluation also includes review of all recommendations identified in the External Quality Review Technical Report for the previous year.

The initial draft of the Medicaid Quality Strategy is also be made available to all members of the Medical Assistance Advisory Council (MAAC) within 30 days of its completion. All committee feedback is taken into consideration in the development of the next Quality Strategy.

Due to members of American Indian descent having the choice to participate in Medicaid managed care through an MCO and PAHP, Iowa’s Tribal Consultation policy is followed regarding the Medicaid Quality Strategy.

Once the initial draft of the Medicaid Quality Strategy has been through the MAAC committee and Tribal Consultation reviews, a copy is submitted to CMS for comment and approval before finalization. This process is completed every time a significant change is made to the Medicaid Quality Strategy.

GOALS

HSAG recommended:

- Revise the Quality Strategy to include all programs supported by the MCOs and PAHPs.
- Develop overarching goals and performance objectives (i.e., quality metrics or standardized performance measures) supporting each overarching goal.
- Ensure each performance objective should follow SMART parameters (i.e., be specific, measurable, achievable, relevant, and time-bound).
- 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.
- Require 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.
- Set MPSs or performance thresholds for HEDIS performance measures which align with HHS’ Quality Strategy goals.

Over the next three years, Iowa and MCPs will promote policy and action to effectively improve the Medicaid program. Activities will be directed toward outcomes that creates healthier

members, building systems, and practices that promote quality and sustainability. Through policy and support of the MCPs, Iowa Medicaid aims to accomplish the following key goals:

Strategic Priority	Goals	Populations
Access to Care	HHS will work collaboratively with the MCOs and Directed Payments to complete the following projects to completion by SFY2027. HHS will complete a project to enhance access to behavioral health services for children with complex behavioral health needs by SFY2027. HHS will complete a comprehensive project around access to care for high-risk pregnancies by SFY2027. HHS will complete a comprehensive project to address access to primary, specialty and dental care by SFY2027. Increase Access to Emergency Services. Increase the number of providers that participate in the Ground Emergency Medical Transportation Directed Payment program to 70 providers. Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last Calendar year.	All
Whole Person Coordinated Care	HHS will increase Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose and Cholesterol), (APM) from 23.6% to 30% By SFY2027. HHS will increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% By SFY2027. HHS will increase Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) from 39.2% to 45%	All

	for initiation and from 15.5% to 20% for engagement By SFY2027. HHS will increase prenatal visits in the first trimester by 5% (59%) by SFY2027. HHS will increase Postpartum visits from 5% (32%) by SFY2027. HHS will Improve Community Integration Management by identifying benchmarks, tracking, and trending LTSS 6, 7, & 8. HHS will Improve LTSS Case Management timeliness of assessments and plans without exemptions to be 95% +/- 5% by SFY2027.	
Health Equity	Managed Care Plans Successfully Create Health Equity Plans and demonstrate a 1% Reduction in Disparities in the following areas: ▪ Behavioral health and substance use disorders. ▪ Maternal Health ▪ Primary and Specialty Care Services ▪ LTSS ▪ Oral Health	All
Program Administration	HHS will complete a comprehensive project around Grievance, Appeals, and Exception to Policy by SFY2027. Iowa Medicaid will complete a project that works toward integration between the medical and dental programs by SFY2027.	All
Voice of the Customer	HHS will complete a comprehensive project around the voice of the customer by SFY2027.	All

1.0 Access to Care

Improve Behavioral Health Network Adequacy

HHS will work collaboratively with the MCOs and Directed Payments to complete the following projects to completion by SFY2027.

- **B3 Pay for Performance Project**: Review, approve, and obtain quarterly updates on the MCO plan to improve access and network adequacy for B3 services, ensuring that pediatrics is an area of focus.
- **Oversight of Provider Network Adequacy Against the Standards**: Include in future MCO contracts to conduct routine secret shopper surveys of their provider networks to assess compliance with network adequacy and appointment availability standards.
- **Identify and Align Behavioral Health Provider Types**: Parter with the managed care plans to improve in identifying behavioral health provider types to improve assessing access to behavioral health services.
- **Grow the Behavioral Health Provider Network**: Obtain quarterly updates from U of I Hospital and Physician on their activities to support additional growth in psychiatric and behavioral health services.
- **Increase Access to Behavioral Health Services Through Follow-Up After Hospitalization**: Obtain quarterly updates from Iowa Hospital Association on their activities to ensure follow-up after hospitalization improves access to behavioral health services.
- **Increase the Focus (U of I Directed Payment)**: on access to care for members with Behavioral Health Diagnosis, and another complex diagnosis or at risk of developing another diagnosis.
- **Behavioral Health and Complex Diagnosis**: Obtain quarterly updates from U of I Hospital and Physician on their activities to improve mental health care for highly complex children and adults and increase availability of care for the individuals with the highest needs for care, especially those with co-occurring behavioral health and developmental disabilities.
    - Complex youth refer to children and adolescents who have profound and interacting needs in various life domains, including family context, function and integration in society. Some of the needs may be mood or anxiety symptoms, disruptive behavior, unusual or odd behaviors present over time, problems with eating or growth, concerns for harm to self or to others on a chronic basis, poor adaptation to living situation changes and poor school or behavioral performance.

HHS will complete a project to enhance access to behavioral health services for children with complex behavioral health needs by SFY2027.

- **School-Based Services:** Update provider manuals, clarify billing requirements, work in collaboration with Invested Iowans (schools, providers, community partners) to increase access to services in school-based settings.
- **EPSDT:** Develop pediatric provider manual, align billing practices across FFS and Iowa's MCOs, increase communication with parents (especially those of older youth) and providers about the periodicity schedule, and develop outreach materials.
- **PMIC:** Provide reimbursement codes to cover services beyond those provided outside the PMIC care team as necessary to adequately treat substance use disorder, sexualized behaviors, autism, and other services needed to support the child.

Improve Access to Maternal Health

HHS will complete a comprehensive project around access to care for high-risk pregnancies by SFY2027.

- **Education:** Improve education on high-risk pregnancies for Family Medicine.
  - High-Risk: The mother, her fetus, or both are at higher risk for problems during pregnancy or delivery than in a typical pregnancy. A high-risk pregnancy may be one that involves chronic health problems, such as diabetes or high blood pressure; infections; complications from a previous pregnancy; or other issues that might arise during pregnancy.
- **U of I Directed Payment:** Increase providers to support high-risk pregnancies.
- Improve outcomes for timely treatment of severe hypertension episodes in pregnant and postpartum patients.
  - Expand number of maternal health providers through recruitment
  - Develop a capacity plan for inpatient and outpatient spaces across UI campuses
  - Increase the number of outreach and telehealth visits across the State of Iowa to support maternal health
- **Expand Medicaid:** to 12 months postpartum.
- **Collaborate:** with Public Health, Maternal Health Task Force, and Iowa Maternal Quality Care Collaborative to identify barriers to care.
- **Focus:** on maternal morbidity and mortality reduction and health equity.

Improve Access to LTSS Services

HCBS Providers will increase their recruitment and retention by 10% from the baseline by the end of the ARPA pre-print as evidenced by provider self-report.

- **ARPA Directed Payment:** The overall goal is to increase HCBS provider capacity to deliver HCB services through capacity and waitlist reduction efforts to support the direct care workforce.

Service utilization for SFY2025 for Targeted HCBS services will increase 10% over the SFY 2024 Service utilization.

- **MCO P4P to improve access for LTSS members**: Review, approve, and obtain quarterly updates on the MCO plan to improve access and network adequacy for LTSS services, ensuring that MCOs address causes for members not receiving needed services and timeliness for needed services. We expect to see that the MCP will increase capacity and reduce the number of individuals that did not utilize a unit of service during a calendar quarter. Increases of 10% each calendar quarter is expected.
- **Increase LTSS Case Management Oversight**: Change the ride along oversight to be a statistically significant sample and include additional questions to ensure restrictive interventions and core elements have been identified.
- **ARPA Directed Payment**: The overall goal is to increase HCBS provider capacity to deliver HCBS services through capacity and waitlist reduction efforts to support the direct care workforce.

Improve Access to Primary Care and Specialty Care

HHS will complete a comprehensive project to address access to primary, specialty and dental care by SFY2027.

- **Additional PIPs:** 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.
- **HSAG Disruption Analysis:** A disruption analysis in future NAV activities provide HHS with valuable information on whether members retained access to their PCPs, and whether provider networks and time/distance access standards were impacted.
- **Provider-to-Member Ratios:** Assess provider-to-member ratios for PCPs, specialists, and dentists to create network adequacy standards.
- **Network Adequacy Standards**: Update its network adequacy standards to include minimum required provider-to-member ratios for PCPs, specialists, and dentists.
- **Assess Network Adequacy Standards:** Require MCPs to conduct routine secret shopper surveys of their provider networks to assess compliance with network adequacy and appointment availability standards.
- **Oversee U of I Directed Payment in Increasing Timely Access:** U if I is the largest referral center in Iowa for complex tertiary/quaternary care and receives referrals from every provider in Iowa. U of I Hospital Directed Payment Expand timely access to care for Medicaid patients for primary and specialty care.
- **Identify and Address:** SDOH issues that are a barrier to access to care.

Increase Access to Emergency Services. Increase the number of providers that participate in the Ground Emergency Medical Transportation Directed Payment program to 70 providers.

- **GEMT Provider Trainings:** Providing more trainings on GEMT to both current prospective enrollees in the program. In addition to increasing awareness, this work also aims to increase compliance and timely filing of required documentation.
- **GEMT Evaluation:** Expand our evaluation related to the call rate and subsequent EMS response to non-emergent calls. This will include a program assessment analyzing the impact of including non-emergent codes as eligible for an add-on rate.
- **Ensure Timely Filing:** Increased work at the provider level to ensure the timely filing of cost reports and other state required documentation to ensure adequate timeframes for State review, consultation, and annual submission.
- **Ensure Payment:** Ensure all non-network providers are treated and paid in accordance with the expectation laid out with the recent publication of CMS Final Rule.
- **Payment Transparency:** Seek methodology adjustments that allow for continued payment transparency while reducing the administrative burden placed on enrolled GEMT providers. One such adjustment being assessed is a pivot from a prospective payment model to a more traditional quarter over quarter payment more reconciled against current claims.

Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last Calendar year.

- **Focus on sub measures:**
  - Oral Evaluation, Dental Services (OEV-CH)
  - Sealant Receipt on Permanent First Molars (SFM-CH)

- **Stakeholder Collaboration:** Iowa Medicaid will collaborate with the I-Smile program and Oral Health and Delivery Systems Bureau and Delta Dental of Iowa Foundation, and Iowa Primary Care Association to discuss enhanced I-Smile @ School Services.
    - Iowa Medicaid will collaborate with other practice models within the state that offer dental sealants in school systems to enhance their programs as possible.
    - Iowa Medicaid will collaborate with the Delta Dental of Iowa Foundation and Iowa Primary Care Association to determine any duplication or policy needs to improve this measure as it relates to stakeholder activities and Medicaid payment.
- **MCP Collaboration:** Iowa Medicaid will work with the PAHPs to implement value-based care strategies that incentivize providers and members to utilize preventive services.
    - Iowa Medicaid will monitor utilization and MCO Social Determinants of Health Dashboard data to determine barriers members experience when trying to access the dentist and work with partners to develop policy that makes it easier for members to access dental care.
    - Iowa Medicaid will engage MCOs in Cavity Free Iowa and Early Periodic Screening Diagnostic Testing (EPSDT) periodicity to encourage increased access to dental prevention at medical appointments.

2.0 Whole Person Coordinated Care

Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis

HHS will increase Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose and Cholesterol), (APM) from 23.6% to 30% by SFY2027.

- **Integrated Health Home (IHH):** Redesign the Health Home Program to improve outcomes, reduce provider barriers, and increase access to whole person care coordination.
- **Behavioral Health and at Risk for Diabetes and Coronary Artery Disease:** Utilize AHRQ Toolkit for additional strategies. Quality Improvement Strategies | Agency for Healthcare Research and Quality (ahrq.gov)
- **MCP Pay for Performance:** Increase the rate of monitoring up to 3%. This activity was recommended by HSAG.
- **Consider a PIP:** Focus on improving the management of children and adolescents on antipsychotics. and/or adults who have co-occurring physical and mental health diagnoses.

HHS will increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% by SFY2027.

- **Integrated Health Home (IHH):** Redesign the Health Home Program to improve outcomes, reduce provider barriers, and increase access to whole person care coordination.

- **MCP Pay for Performance:** Increase the rate of monitoring up to 3%. This activity was recommended by HSAG.
- **Consider a PIP:** Focus on improving the management of adults who have co-occurring physical and mental health diagnoses.

HHS will increase Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) from 39.2% to 45% for initiation and from 15.5% to 20% for engagement By SFY2027.

- **Integrated Health Home (IHH):** 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 behavioral health and substance use disorder diagnoses through CCBHC Demonstration.
- **The use of CoCM:** The U of I directed payment has a specific focus on the use of CoCM to increase coordination of members with a behavioral health diagnosis.
- **Expand the crisis stabilization unit (CSU):** at UI Health Care to include children and adolescent patients as well as increase the number of CSU beds. Our goal is to increase adult beds from 12 to 16 and add 5 beds for children/adolescent patients.

Improve Prenatal and Postpartum Comprehensive Care Management

HHS will increase prenatal visits in the first trimester by 5% (59%) by SFY2027.

- **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.
- **Education:** Educate providers on reimbursement processes outside of the bundled payment.
- **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.

HHS will increase Postpartum visits from 5% (32%) by SFY2027.

- **Maternal Health Social Drivers:** Transportation to get food. Project started to provide transportation for doctor's appointments, food etc.
- **Expand Medicaid:** to 12 months postpartum.
- **Collaboration:** with Public Health, Maternal Health Task Force, and Iowa Maternal Quality Care Collaborative to identify best practices in postpartum care.
- **Education:** Work to educate stakeholders to understand the added benefit for maternal health 12 months post-partum.
- **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.

Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services.

HHS will Improve Community Integration Management by identifying benchmarks, tracking, and trending LTSS 6, 7, & 8.

- **Community Integration Management:** is a new program and work may need to occur for improvement.
    - LTSS-6: LTSS Admission to a Facility from the Community;
    - LTSS-7: LTSS Minimizing Facility Length of Stay;
    - LTSS-8: LTSS Successful Transition After Long-Term Facility Stay

HHS will Improve LTSS Case Management timeliness of assessments and plans without exemptions to be 95% +/- 5% by SFY2027.

- **MCO P4P to improve access for LTSS members**: Review, approve, and obtain quarterly updates on the MCO plan to improve access and network adequacy for LTSS services, ensuring that MCOs 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.
- **Increase LTSS Case Management Oversight**: Change the ride along oversight to be a statistically significant sample and include additional questions to ensure restrictive interventions and core elements have been identified. HHS is creating core competencies for Case Managers managing LTSS. This includes IHH, TCMs and CBCMs.
- **Create Benchmarks**:
    - Assessment: LTSS-1: LTSS Comprehensive Assessment and Update
    - Person-centered care planning: LTSS-2: LTSS Comprehensive Care Plan and Update
        - 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

3.0 Health Equity

Evaluate service delivery and engagement through Health Equity lens by analyzing behavioral health, maternal health, primary care and specialty care services.

Measures are stratified by:

- Race
- Ethnicity
- Age
- Geography

Address Disparities in Behavioral Health

Managed Care Plans Successfully Create Health Equity Plans and demonstrate a 1% reduction in disparities for Black members with behavioral health and substance use disorders.

- **Support Value Based Arrangements**: The Quality Committee oversees the MCP's Health Equity Plans and obtains quarterly updates on the MCO plan to reduce disparities in care. Measure of focus include:
  - Anti-depressant medication adherence rate
  - IET
  - FUH
- **Development:** of Health Equity Plans or meet certain requirements.
- **Health Equity Project**: In SFY 2026 P4P for both PAHPs and MCOs will include Health Equity as a project as we have not included the newest MCO nor the PAHPs in this exercise.
- **Identify Disparities**: across the Medicaid membership to provide recommendations for areas of focus for the MCPs.

Support Health Equity for members with a diagnosis of mental health and/ or substance use disorder through the directed payment programs through the addition of metrics at the provider level to support disparities in care by SFY2027.

- **Develop basic requirements**: for providers to follow to support the development of Health Equity Plans for U of I, and All Hospital Directed Payments.
- **Oversee:** the Health Equity Plans with quarterly updates to ensure progress is made in reducing disparities.

Address Disparities in Maternal Health

Managed Care Plans Successfully Create Health Equity Plans and demonstrate a 1% reduction in disparities for Black members with maternal health needs.

- **Support Value Based Arrangements**: The Quality Committee oversees the MCP's Health Equity Plans and obtains quarterly updates on the MCO plan to reduce disparities in care. Measure of focus include:
  - Low birth rate
  - Prenatal care in the first trimester
  - Development of Health Equity Plans or meet certain requirements.
- **Health Equity Project:** In SFY 2026 P4P for both PAHPs and MCOs will include Health Equity as a project as we have not included the newest MCO nor the PAHPs in this exercise.
- **Identify disparities:** across the Medicaid membership to provide recommendations for areas of focus for the MCPs.
- **Directed Payments**: Support Health Equity for members with a maternal health need through the directed payment programs through the addition of metrics at the provider level to support disparities in care by SFY2027.
  - Develop basic requirements for providers to follow to support the development of Health Equity Plans for U of I, and All Hospital Directed Payments.

- Oversee the Health Equity Plans with quarterly updates to ensure progress is made in reducing disparities.

Address Disparities in LTSS Services

Managed Care Plans Successfully Create Health Equity Plans and demonstrate a 1% reduction in disparities for Black members enrolled in HCBS Services.

- **Health Equity Project:** In SFY 2026 P4P for both PAHPs and MCOs will include Health Equity as a project as we have not included the newest MCO nor the PAHPs in this exercise.
- **Identify disparities**: across the Medicaid membership to provide recommendations for areas of focus for the MCPs.

Address Disparities in Primary and Specialty Care Services

Managed Care Plans Successfully Create Health Equity Plans and demonstrate a 1% reduction in disparities for Black members for Primary and Specialty Care Services.

- **Health Equity Project**: In SFY 2026 P4P for both PAHPs and MCOs will include Health Equity as a project as we have not included the newest MCO nor the PAHPs in this exercise.
  - Colorectal Cancer Screening
  - Adolescent well Child Visits
  - A1C Control
  - Controlling High Blood Pressure
- **Identify disparities:** across the Medicaid membership to provide recommendations for areas of focus for the MCPs.
- **Directed Payments:** Support Health Equity for members with a maternal health need through the directed payment programs through the addition of metrics at the provider level to support disparities in care by SFY2027.
  - Develop basic requirements for providers to follow to support the development of Health Equity Plans for U of I, and All Hospital Directed Payments.
  - Oversee the Health Equity Plans with quarterly updates to ensure progress is made in reducing disparities.

HHS will complete a project by SFY2027 that implements a framework to track, trend and baseline Health Equity data.

- **Health Equity Project**: In SFY 2026 P4P for both PAHPs and MCOs will include Health Equity as a project as we have not included the newest MCO nor the PAHPs in this exercise.
  - Colorectal Cancer Screening
  - Adolescent well Child Visits
  - A1C Control
  - Controlling High Blood Pressure
- **Identify disparities:** across the Medicaid membership to provide recommendations for areas of focus for the MCPs.

- **Directed Payments:** Support Health Equity for members with a maternal health need through the directed payment programs through the addition of metrics at the provider level to support disparities in care by SFY2027.
    - Develop basic requirements for providers to follow to support the development of Health Equity Plans for U of I, and All Hospital Directed Payments.
    - Oversee the Health Equity Plans with quarterly updates to ensure progress is made in reducing disparities.

4.0 Program Administration

Grievances, Appeals, and Exception to Policy

HHS will complete a comprehensive project around Grievance, Appeals, and Exception to Policy by SFY2027.

- **Quality Assurance:** Review MCP practices for grievance and appeals ensuring they meet state and federal requirements.
- **Quality Control:** 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 Planning:** Identify areas for improvement to increase member satisfaction when concerns are identified.
- **Quality Improvement:** Create a project to address any identified areas of deficiencies and opportunities for improvement.

Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs.

Iowa Medicaid will complete a project that works toward integration between the medical and dental programs by SFY2027.

- **Develop policy:** to incorporate the use of ICD-10 coding on dental claims to provide diagnosis for needed treatment, to aid in data analysis and streamline referrals.
- **MCP Contract Lanaguage:** Strengthen MCP contract language and performance measures to incentivize increased coordination of medical, dental and community services.

5.0 Voice of the Customer

CAHPS Survey Transition

HHS will complete a comprehensive project around the voice of the customer by SFY2027.

- **Benchmarks**: Use the national average as a benchmark for CAHPS survey questions.
- **Focus** Areas:
    - Continuity of Care
    - Experience of care stratified by waiver.
    - Questions around Grievance and appeals

  - 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
- **Quality Planning**: Identify areas for improvement to increase member satisfaction when concerns are identified.
- **Quality Improvement:** Create a project to address any identified areas of deficiencies and opportunities for improvement.

QUALITY OF CARE

Public Posting of Quality Measures and Performance Outcomes

Monthly and quarterly MCPs performance reports are posted to the Iowa Department of Human Services website at: Microsoft Power BI (powerbigov.us).

Long Term Services and Supports Performance Measures

Monthly and quarterly performance reports are posted to the Iowa Department of Human Services website at: Microsoft Power BI (powerbigov.us).

Performance Improvement Projects (PIP) and PIP Interventions

MCO PIP

PIP Topic	PIP Aim	PIP Intervention
ADHD-follow up	Finalizing PIP Aim	In Development
SDOH: Increase Screening	Do targeted interventions increase the percentage of unduplicated newly enrolled Medicaid members during the measurement period that were screened for social determinants of health (SDOH) no later than ninety days after the effective date of enrollment? Do targeted interventions increase the percentage of unduplicated existing Medicaid members who were due for a subsequent screening during the measurement period, were continuously enrolled for the prior 12 months and were screened for SDOH during the measurement period?	In Development

PAHP PIP

PIP Topic	PIP AIM	PIP Intervention
Annual Dental Preventive Visits	demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of initiated intervention(s).	Changed member service representative talking points, developed internal procedural changes, improved customer service notes, and developed a provider information resource log and a probing questions resource document. Dental Kits consist of members receiving a mailed kit, which included a toothbrush, toothpaste, dental floss, and information about their DWP benefits. Outbound calls consist of identified members receiving an outbound call from a live representative to educate them about their benefits, help them answer any questions and find a provider, and encourage members to update their contact information. Utilized targeted tele-dentistry through partnership with TeleDentistry.com for 3-year-old DWP Kids and Hawki member populations who had not received fluoride services or any preventive service within the last 12 months.
Increase the Percentage of Dental Services (MCNA)	Demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of initiated intervention(s).	Conduct outbound calls to members who have not completed a preventive dental visit to educate them on their available benefits for dental checkups as well as the importance of routine dental care to prevent further problems such as gum disease. Members are also encouraged to schedule an appointment

		and offered assistance if needed. Members who have not received a preventive service within the last six months receive an educational postcard educating them on the importance of preventive services and encouraging them to schedule a preventive checkup. Providers receive an additional $10 when they see members for a recall visit.

Transition of Care Policy

The State makes its transition of care policy publicly available and provide instructions to members in the member handbook and can be accessed on the website. The member handbook describes how the member can access continued services upon transition. MCPs must implement mechanisms to ensure continuity of care of members transitioning in and out of enrollment. This includes the following transitions:

- The member has access to services consistent with the services received prior to transitioning and is permitted to retain their current provider for 90 days if their provider is not in the MCP network.
- The member is referred to appropriate providers of services that are in the network.
- The Agency, in the case of FFS, or the MCP that was previously serving the member, fully and timely complies with requests for historical utilization data from the new member.
- The member's new provider(s) can obtain copies of the member's medical records, as appropriate.
- Any other necessary procedures to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.
- A process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR 170.213. Such information received by the MCP must be incorporated into the member's record. With approval and at the direction of the member or the member's personal representative, the MCP must:
    - Receive all such data for a current member from any other payer that has provided coverage to the member within the preceding five years;
    - Any time the member is currently enrolled in the MCP and up to 5 years after disenrollment, send all such data to any other payer that currently covers the member or a payer the member or the member's personal representative specifically requests receive the data; and

    - Send data received from another MCP under this paragraph in the electronic form and format it was received.
- A member can change MCPs under the following circumstances:
    - Initial enrollment with the MCP;
    - Transitions between MCPs during the first 90 days of enrollment;
    - Transition for good cause.

MCP transition of care includes the following requirements:

- Transfer prior authorization and clinical data to the receiving MCP.
- The initial contract year provisions for access to out of network providers.

All plans are required through contract to assure transition of care requirements as federally required for managed care organizations. The MCPs submit annual transition of care plans for review during the contract year. Once a member is deemed eligible for Medicaid, the member is passively assigned to a MCP for services and receives a Welcome Packet to Iowa Medicaid and their new MCP assignment. During transition of care, members are allowed 90 days from their passive MCP assignment to contact Iowa Medicaid Member Services, the Enrollment Broker for Iowa Medicaid, to assure members can switch plans at their discretion. Members may receive services and assistance transferring their records with their established provider during the first 90 days of enrollment, regardless of whether the provider is in-network with the MCP. Iowa Medicaid assures MCP electronic exchange of beneficiary data and MCP assignment changes through the 834 files, which updates eligibility daily.

Health Disparities Plan

Iowa Medicaid collects member race and ethnicity, as well as aid type category, age, and gender. This information is passed to MCPs through enrollment files. These data fields support MCP quality assurance activities and contractual requirements that MCPs are culturally competent and deliver culturally appropriate services. Iowa Medicaid Quality Committee is currently working on a Health Equity plan for Iowa Medicaid that will evaluate service delivery and member engagement through a lens of equity, as outlined in Iowa Medicaid's strategic plan. The future Health Equity Plan will incorporate dental and medical services, and consider the following elements for each disparity factor (age, race, ethnicity, sex, primary language, and disability status) within our disparity plan:

- Inclusion of a description of the state's plan to reduce disparities by target population and populations (such as Children's Health Insurance Program (CHIP) and enrollees with behavioral health needs).
- Use of a streamlined oral health equity risk assessment tool (OHEA) and social determinants of health risk assessment currently being gathered by the MCOs, to capture data on social determinants of health and chronic conditions, as well as engage member referrals.
- Partnership with other government entities such as the Department of Public Health, the Department on Aging, and Child Health Specialty Clinics to align potential gaps in care for these populations and develop multi-pronged strategies that support improved access to care and prevention.
- Inclusion of members deemed disabled Disability Determination Services or, in some exceptions, receive Social Security disability benefits.

- Disability determinations are made by the Iowa Disability Determination Services (DDS), part of Iowa Workforce Development (IWD). DDS works with those who apply for and receive disability benefits from Social Security Administration (SSA). Disability Determination Services | Iowa Workforce Development Those benefits include:
  - Social Security Disability Insurance (SSDI) and, or
  - Supplemental Security Income (SSI).

The SFY26 contract with the MCPs will require the plans to provide a plan on how they will address health equity issues in 2026, aligning with goals and objectives set out by Iowa Medicaid. The criteria for the Health Equity plan will be determined and reviewed by Iowa Medicaid's Quality Committee, working to align with MCP health equity strategies. At a minimum, the plan will require the MCPs to submit how they will evaluate, analyze, and improve access and quality of care for patients in unique populations, using claims and risk assessment data. Disability status and Primary Language will be two of the areas that Iowa Medicaid Quality Committee considers as requirements for the MCPs Health Equity plans.

Persons who need Long Term Services and Supports or Persons with Special Health Care Needs

Iowans access navigation supports through a variety of community-based entities. These informal navigators have knowledge, training and expertise in health and human service system navigation including Medicaid program eligibility, community-based services for aging individuals and those with disabilities including the Medicaid HCBS programs to provide information and referral services in a fair, accurate, and impartial manner.

MONITORING AND COMPLIANCE

Network Adequacy and Availability of Services

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.

Managed Care Organizations

Provider Type	Member Description	Time/Distance
Adult - PCP	All Adults (19 or older)	30 minutes or miles
Pediatric - PCP	All Children (0 to 18)	30 minutes or miles
Allergy - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Cardiology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population

Dermatology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Endocrinology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Gastroenterology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
General Surgery - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Hematology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Nephrology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Neurology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Neurosurgery - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Obstetrics and Gynecology (OB/GYN) - Adult	All Non-Dual Females (12 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Occupational Therapy - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population

Oncology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Ophthalmology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Orthopedics - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Otolaryngology (ENT) - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Pathology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Physical Therapy- Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Psychiatry- Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Pulmonology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Radiology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Reconstructive Surgery - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population

Rheumatology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Speech Therapy - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Urology - Adult	All Non-Dual Adults (19 or older)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Allergy - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Cardiology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Dermatology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Endocrinology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Gastroenterology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
General Surgery - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Hematology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population

Neonatology - Pediatric	All Non-Dual Children (under 1)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Nephrology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Neurology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Oncology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Ophthalmology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Orthopedics - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Otolaryngology (ENT) - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Pulmonology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Rheumatology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population
Urology - Pediatric	All Non-Dual Children (0 to 18)	60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population

Dental

Member/Provider Ratios

Iowa Medicaid monitors member/provider ratios by county to assure the PAHPs maintain an appropriate mix of general dentist and specialty provider availability by practice type, member demographic geography within the county. Currently Iowa has 63 of 100 counties recognized as Dental Health Professional Shortage Areas, for both geographic and population needs criteria. Iowa Medicaid requires the plans submit monthly Provider Network Files, which provide insight into the provider network, including providers accepting new members, those who are fully credentialled, those who are providing services actively, and the location of each provider. While an ideal member/provider ratio has not yet been determined, Iowa Medicaid continues to monitor access to members and is considering ways to work with EQRO and other vendors to complete an analysis of adequate member/provider ratios for pediatric and adult members.

Assurance of Adequate Capacity and Services

Current network capacity standards set forth in the contract area represented in the table below.
In general, the PAHPs will provide available, accessible, and adequate numbers of providers for the provision of covered services, including any emergency services, 24 hours a day, 7 day a week basis. Geo Access maps posted to the website can be found here: Medicaid Performance and Reports | Health & Human Services (iowa.gov)

Provider Type	Standard
GENERAL DENTIST (DWP Adults and Kids)	DISTANCE: 60 miles or 60 minutes in rural areas; 30 miles or 30 minutes in urban areas
PEDIATRIC DENTIST (Hawki program)	DISTANCE: 60 miles or 60 minutes in rural areas; 30 miles or 30 minutes in urban areas

* If a county does not have enough providers licensed, certified, or available, the access standard will be based on the community standard and will be justified and documented to the state.

Availability of Services

Iowa Medicaid will be adding additional language to the SFY25 contract to include access standards relating to timeliness of appointment, including the below availability of service standards. Iowa Medicaid plans to monitor this requirement using our EQRO vendor, to perform secret shopper calls to offices to assure the plans meet the below access standards.

Primary Care Dentist & Specialist Access Standards

a. *Appointment Times*: Not to exceed four (4) to six (6) weeks from the date of a patient's request for a routine appointment, within forty-eight (48) hours for persistent symptoms and urgent within one (1) day.

In addition, Iowa Medicaid is internally reviewing network adequacy through an evaluation of providers who are actively accepting new members, as this has shown to be a potential concern for the network, when providers are active and credentialled, however not accessible to new members of the PAHP's network, due to a closed panel. Workforce shortages are also a

growing concern for dental practices in the state and dental providers and their auxiliary staff (dental hygienists and dental assistants).

Clinical Practice Guidelines

Evidence-Based Clinical Practices

- Quality and utilization management programs are based on valid and reliable clinical evidence or a consensus of providers in the particular field. Evidence-based programming supports member access to care and availability of services by ensuring that inappropriate procedural barriers to care are not in place. The Agency ensures through the MCP contracts, that the MCPs evidence-based clinical guidelines are based on valid and reliable clinical evidence or a consensus of providers in the particular field, consider the needs of the members, are adopted in consultation with network providers, and are reviewed and updated periodically as appropriate through the Medicaid CAC. MCPs disseminates guidelines to providers, members, and potential members as appropriate.
- Guidelines are applied to utilization management, member education, and coverage of services. Examples of evidence-based approaches include scheduled reviews of national utilization management policies, reviews of appeals metrics to identify trends, and evaluating quality and utilization management activities that have been implemented.
- Iowa has a robust number of services on the fee schedule to allow providers the ability to treat the member as they determine appropriate and not limit services that might improve the overall health of the member. However, some services must be prior authorized prior to delivery.
- MCPs submit clinical practice guidelines and standards used in approving and denying claims, which follow best practice. Iowa Medicaid follows these guidelines in their Fee for Service program to assure that services are medically necessary and provided as clinically appropriate.

Advisory Groups

The state promotes appropriate utilization of services within acceptable standards of medical practice through advisory committees. A link to the Advisory Committees can be found: Advisory Groups | Health & Human Services (iowa.gov)

Stakeholder Advisory Board

The Stakeholder Advisory Board provides input on issues such as service delivery, quality of care, member rights and responsibilities, resolution of grievances and appeals, operational issues, program monitoring and evaluation, member and provider education, and priority issues identified by members. At least 51% of each MCO Stakeholder Advisory Board is comprised of members and/or their representatives. Provider membership includes representatives of different services areas, such as nursing facility providers, behavioral health providers, primary care, and others. MCOs have plans in place to encourage participation and have minutes available to HHS upon request. Any issues that are identified by the Stakeholder Advisory Board are incorporated in MCO planning, operations, and quality work plans.

Managed Care Plan Quality Management/Quality Improvement (QM/QI) Committee

In addition to stakeholder recommendations, the MCOs each have a Quality Management/ Quality Improvement (QM/QI) Committee. This is a group of medical, behavioral health, public health, and long-term care staff and network providers that meets periodically (usually quarterly) to analyze and evaluate the result of QM/QI activities, recommend policy, ensure provider involvement, institute needed action, and ensure appropriate follow-up occurs. MCOs report the committee's activities on a quarterly basis using templates prescribed by HHS.

Maternal Health Task Force

HHS collaborates with other agencies of state government to inform and focus quality improvement activities, such as the Department of Public Health or the Department of Education, both of which operate programs designed for early identification and assessment of disease processes and immunization patterns. HHS ensures these efforts are appropriately prioritized, aligned, and coordinated with our MCOs. A good example is the Maternal Health Task Force, which meets quarterly. Through the task force, DHS in cooperation with IDPH reviews and evaluates high-risk births of medical assistance recipients and evaluates services to reduce risk by creating actionable objectives based on data; the goal is to improve parity in access and outcomes in the maternal population in the state of Iowa with a focus on the Medicaid population.

Clinical Advisory Committee (CAC)

In addition to interagency cooperation, input to the quality plan is also periodically reviewed by Medicaid Clinical Advisory Committee (CAC)**.** The purpose of the CAC is to increase the efficiency, quality, and effectiveness of the Medicaid healthcare system. The CAC provides a process for physician/provider intervention to promote quality care, member safety, cost effectiveness and positive physician/provider relations through discussion about Medicaid benefits and healthcare services. This committee meets quarterly with managed care being a standard agenda item. Acting under the direction of the Medicaid Medical Director, the CAC provides guidance to HHS regarding clinical policies of the managed care program, suggests areas of oversight, reviews, and informs various quality programs.

Medical Assistance Advisory Council (MAAC)

The purpose of the Medical Assistance Advisory Council (MAAC) is to "Advise the Director about health and medical care services under the medical assistance program." The Council is mandated by federal law and further established in Iowa Code. While the CAC is focused on clinical aspects of service delivery and policy, the MAAC oversees the Medicaid program more broadly, including Long Term Support Services, payment issues, network adequacy and more.

Medicaid Quality Committee

The Medicaid Quality Committee works to oversee the quality plan and implements strategies to ensure that the triple aim is met. These strategies include:

- The development of Pay for Performance measures for the MCOs and other programs as needed.
- Support policy in deciding measures to assess effectiveness of programs.
- Complete a formal review of the Quality Strategy.
- Review and approve or deny any updates or changes to the Quality Strategy as needed.

- Conduct a formal evaluation of the effectiveness of the Quality Strategy over those previous three years.
- Move the quality strategy through the update and approval process.

Council on Human Services

The Council on Human Services advises on matters within the jurisdiction of all of HHS. The Council on Human Services provides recommendations to the Governor. The Council meets monthly.

Pharmaceutical and Therapeutics (P&T) Committee

The Pharmaceutical and Therapeutics (P&T) Committee is charged by law with developing and providing ongoing review of the Preferred Drug List (PDL). The PDL is a list of drugs approved by the Department to be prescribed for Medicaid members. Drugs not on the PDL may not be covered by Medicaid. http://www.iowamedicaidpdl.com/pt_committee_info

Drug Utilization Review (DUR) Commission

CMS also requires state Medicaid programs to have a Drug Utilization Review (DUR) commission consisting of prospective DUR, retrospective DUR, and an educational program. Medicaid Pharmacy | Health & Human Services

Children's Behavioral Health System State Board

The Children's Behavioral Health System State Board (Children's Board) is the single point of responsibility in the implementation and management of a Children's Mental Health System (Children's System) that is committed to improving children's well-being, building healthy and resilient children, providing for educational growth, and coordinating medical and mental health care for those in need.

Mental Health Planning and Advisory Council

The Iowa Mental Health Planning and Advisory Council (MHPC) is a state advisory body authorized by federal law (42 U.S.C. Section 300x) and required as a condition for the receipt of federal Community Mental Health Services Block Grant funding. The objective of block grant funding is to support the State in providing comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system.

Council on Human Services

The Council on Human Services acts in a policymaking and advisory capacity on matters within the jurisdiction of the department

Iowa Mental Health and Disability Services Commission

The Iowa Mental Health and Disability Services (MHDS) Commission is the state policy-making body for the provision of services to persons with mental illness, intellectual disabilities or other developmental disabilities, or brain injury.

Intermediate Sanctions

HHS may impose sanctions due to noncompliance with contract requirements or applicable federal or State laws. Find our reports 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.

Iowa Medicaid has not applied any sanctions to the dental PAHPs regarding contract compliance. However, Iowa Medicaid has implemented remedy letters to address concerns with contractor performance related to call center compliance, reporting timeliness, and approval of Iowa Medicaid communications.

EXTERNAL QUALITY REVIEW ARRANGEMENTS

EQR Arrangements Review of Compliance with Medicaid and CHIP Managed Care Regulations.

HHS contracts with its EQRO to conduct annual comprehensive site reviews of the MCPs to determine compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330, in addition to applicable state-specific contract requirements established by HHS.

To evaluate the MCPs' implementation of the requirements, a wide range of documents is reviewed including, but not limited to, policies and procedures, member and provider materials, and various assessments, reports, and evaluations. A review of individual case files and system demonstrations, as well as interviews of key staff members is also conducted to determine compliance. Any compliance review standards that are not fully compliant (<100 percent) will require corrective action by the MCP.

HHS follows a three-year cycle of compliance reviews in which seven of the 14 standards are reviewed in Year One, the remaining seven standards are reviewed in Year Two, and a corrective action plan review occurs in Year Three.

Standards	Associated Federal Citation[2]		Year One	Year Two	Year Three
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of the MCP's Year One and Year Two Corrective Action Plans (CAPs)
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Post stabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Sub-contractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[3]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240		✓	

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

[2] The current compliance review three-year cycle began in CY 2024.

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

EQR Non-Duplication Option

This is not an activity that we do.