Iowa Medicaid

Iowa HHS

Calendar Year 2025 External Quality Review Technical Report

April 2026

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

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

Iowa Medicaid is the division of HHS that administers and oversees the Iowa Managed Care Program, which contracts with three managed care organizations (MCOs) to provide physical health, behavioral health, and long-term services and supports (LTSS) to Medicaid members. The Iowa Managed Care Program consists of two primary coverage groups: (1) IA Health Link and (2) Healthy and Well Kids in Iowa, also known as Hawki (Iowa's Children's Health Insurance Program [CHIP]). HHS also contracts with two prepaid ambulatory health plans (PAHPs) to provide dental benefits for Medicaid (Dental Wellness Plan [DWP] Adults and DWP Kids) and Hawki members. The MCOs and PAHPs contracted with HHS during calendar year (CY) 2025 are displayed in Table 1-1.

Table 1-1—MCPs* in Iowa

MCO Name	MCO Abbreviation
Iowa Total Care, Inc.	ITC
Molina Healthcare of Iowa, Inc.	MOL
Wellpoint Iowa, Inc.	WLP
PAHP Name	**PAHP Abbreviation**
Delta Dental of Iowa	DDIA
Managed Care of North America Dental	MCNA

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

Scope of External Quality Review Activities

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

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 27, 2026.

implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective, high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members. For the CY 2025 assessment, no MCPs were exempt from the EQR conducted by HSAG. HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 that were performed during the preceding 12 months to derive conclusions and make recommendations about the quality, timeliness, and accessibility of care and services provided by each MCP. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MCP used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	The activity assesses whether the performance measures calculated by an MCP are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which a Medicaid and CHIP MCP is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations
Network Adequacy Validation (NAV)	This activity assesses the accuracy of the network adequacy indicators reported by an MCP and the extent to which an MCP has met the quantitative network adequacy standards defined by the State.	Protocol 4. Validation of Network Adequacy
Encounter Data Validation (EDV)	The activity validates the accuracy and completeness of encounter data submitted by an MCP.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] Analysis	This activity assesses member experience with an MCP and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys
Quality Rating (i.e., Scorecard)	This activity assigns a quality rating (using indicators of clinical quality management; member satisfaction; and/or plan efficiency, affordability, and management) to each MCP serving Medicaid managed care members that enables members and potential members to consider quality when choosing an MCP.	Protocol 10. Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans*

* During the time period of this activity, CMS had not yet issued the associated EQR protocol.

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

Iowa Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR findings from the CY 2025 activities to comprehensively assess the MCPs' performance in providing quality, timely, and accessible healthcare services to Medicaid and Hawki members. For each MCP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MCP's performance, which can be found in Section 3 and Section 4 of this report. The overall findings and conclusions for all MCPs were also compared and analyzed to develop overarching conclusions and recommendations for the Iowa Managed Care Program. Table 1-3 highlights substantive conclusions and actionable state-specific recommendations, when applicable, for HHS to drive progress toward achieving the strategic priorities of the Iowa HHS Medicaid Quality Strategy and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members. Table 1-3 displays each Iowa HHS Medicaid Quality Strategy priority and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (●) impacted the Iowa Managed Care Program's progress toward achieving the applicable priorities, and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to Medicaid members. If no trends were identified through an EQR activity that substantially impacted a priority, or EQR activities did not produce data for an Iowa HHS Medicaid Quality Strategy objective, a dash (–) is noted in Table 1-3.

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

Performance Impact on Strategic Priorities and Objectives		Performance Domain
Strategic Priority 1.0—Access to Care		
✓	The aggregated statewide rate for *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—7-Day and 30-Day Follow-Up—Total* performance measures were at or above the 90th percentile, positively impacting the Iowa HHS Medicaid Quality Strategy objective to *Improve Behavioral Health Network Adequacy*.	☒ Quality ☒ Timeliness ☒ Access
✓	Both PAHPs demonstrated statistically significant improvement in performance as compared to the baseline for the DWP Kids performance indicator for the preventive dental visits PIP activity. These results demonstrate progress for this population toward achieving HHS' Strategic Priority for increasing the number of members who access dental care.	
✗	The statewide aggregate rate for *Access to Dental Services* performance measure for DWP Adults (24.35 percent) and DWP Kids (51.82 percent) indicated that additional opportunities exist to improve these performance measure rates to positively impact HHS' Strategic Priority for increasing the number of members who accessed dental care.	
–	Through the NAV activity, four of five MCPs demonstrated that during the time period under review, they were either not completing a survey or were not comprehensively completing a survey in accordance with HHS indicators for appointment wait times.	

	Performance Impact on Strategic Priorities and Objectives	Performance Domain
–	The EQR activities do not produce sufficient data to assess the impact of the *Improve Access to Maternal Health* and *Improve Access to LTSS Services* Iowa HHS Medicaid Quality Strategy objectives, or the *Sealant Receipt on Permanent First Molars* indicator under the *Improve Access to Primary Care and Specialty Care* objective.	
Strategic Priority 2.0—Whole Person Coordinated Care		
✓	The aggregated statewide Healthcare Effectiveness Data Information Set (HEDIS®)[3] rate for *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* was 82.57 percent, which achieved the Iowa HHS Medicaid Quality Strategy objective to *Increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% by SFY2027*.	
✓	The aggregated statewide HEDIS rate for *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total* was 52.26 percent and the *Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total* aggregated statewide HEDIS rate was 19.16 percent, indicating progress was made toward achieving the Iowa HHS Medicaid Quality Strategy objective to *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.*	
×	The *Timeliness of Prenatal Care* measure had statewide aggregate rates of 84.90 percent, which was a decrease from the prior year, indicating negative impact to the *Improve Prenatal and Postpartum Comprehensive Care Management* Iowa HHS Medicaid Quality Strategy objective.	
●	The aggregated statewide HEDIS rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* increased minimally from 26.94 percent to 27.81 percent, which continues to be an improvement from the 23.6 percent baseline rate identified in the Iowa HHS Medicaid Quality Strategy. This performance demonstrates minimal impact for the Iowa HHS Medicaid Quality Strategy objective to *Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis*.	
●	The *Postpartum Care* measure had a statewide aggregate rate of 83.65 percent for postpartum care, which was a slight increase from the prior year's rate, indicating minimal impact was made to the *Improve Prenatal and Postpartum Comprehensive Care Management* Iowa HHS Medicaid Quality Strategy objective.	
–	While statewide aggregate rates were reported through the PMV activity for MLTSS measures (*Admission to a Facility from the Community*, *Minimizing Facility Length of Stay*, and *Successful Transition After Long-Term Facility Stay*), the Iowa HHS Medicaid Quality Strategy did not include performance targets for these measures. Therefore, the impact to the objective to *Improve Whole Person Coordinated Care for Member Enrolled in LTSS Services* could not be assessed.	

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

	Performance Impact on Strategic Priorities and Objectives	Performance Domain
Strategic Priority 3.0—Health Equity		
–	The EQR activities did not produce sufficient data to assess the impact to the *Address Disparities in Behavioral Health and Substance Use Disorders*, *Maternal Health*, *Primary and Specialty Care Services*, *LTSS*, and *Oral Health* Iowa HHS Medicaid Quality Strategy objectives. Of note, while performance measures that align with the Iowa HHS Medicaid Quality Strategy objectives are collected through the HEDIS audit process, the data included through the technical report process are not stratified by race, ethnicity, age, or geography.	☒ Quality ☐ Timeliness ☒ Access
–	The aggregated findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact that HHS' value-based arrangements have on reducing disparities in care in the focus area of low birth weight.	
Strategic Priority 4.0—Program Administration		
–	The EQR activities did not produce data to assess the impact on the Grievances, Appeals, and Exception to Policy objective.	☒ Quality ☐ Timeliness ☐ Access
Strategic Priority 5.0—Voice of the Customer		
✓	The MCO Program (i.e., statewide aggregate rate) received a rate of 49.53 percent for the CAHPS measure, *Discussing Cessation Medications*, for the adult Medicaid population, which was higher than the CY 2024 rate.	☒ Quality ☐ Timeliness ☐ Access
✓	For the child Medicaid population *Rating of Personal Doctor* CAHPS measure, the statewide aggregate rate was 79.55 percent, which was statistically significantly higher than the 2024 national average.	
✓	The child Medicaid population *Getting Needed Care* (88.80 percent), *Getting Care Quickly* (91.47 percent), and *How Well Doctors Communicate* (95.96 percent) CAHPS measures were statistically significantly higher than the 2024 national average.	
✓	For the child Medicaid population *Customer Service* CAHPS measure, the statewide aggregate rate was 89.96 percent, which was higher than the CY 2024 rate.	
✓	The adult Medicaid population *Getting Needed Care* (86.43 percent), *Getting Care Quickly* (85.64 percent), and *How Well Doctors Communicate* (95.32 percent) CAHPS measures were statistically significantly higher than the 2024 national average.	
✗	For the adult Medicaid population *Rating of All Health Care* (53.00 percent), *Rating of Specialist Seen Most Often* (61.70 percent), and *Rating of Health Plan* (58.26 percent) CAHPS measures, the statewide aggregate rates were statistically significantly lower than the 2024 national average.	
✗	For the child Medicaid population *Rating of Health Plan* CAHPS measure, the statewide aggregate rate was 67.79 percent, which was lower than the CY 2024 rate and statistically significantly lower than the 2024 national average.	

Performance Impact on Strategic Priorities and Objectives		Performance Domain
–	The aggregated findings for the EQR activities did not produce data for HSAG to comprehensively assess the impact to HHS' focus areas through surveys for continuity of care, experience of care stratified by waiver, and questions around grievances and appeals.	

Recommendations

Based on findings identified through the EQR activities that impacted the goals and objectives in the Iowa HHS Medicaid Quality Strategy, HSAG has identified the following recommendations to support improvement in the quality, timeliness, and access to healthcare services furnished to Iowa Managed Care Program members:

- To further enhance HHS' ability to measure the strategic priorities indicated in the Iowa HHS Medicaid Quality Strategy, HSAG recommends that HHS consider including specific, measurable, attainable, and timely goals and corresponding objectives for each of the strategic priorities and revise the Iowa HHS Medicaid Quality Strategy to reflect these updates. For example, related to the Access to Care strategic priority, HHS could consider adding objectives that tie to national standardized performance measures for all HHS priority areas including behavioral health, maternal health, LTSS, primary care, and specialty care, and set benchmarks for each objective. Additionally, HSAG recommends that HHS consider establishing corresponding objectives that align specifically to dental health outcomes for all five of HHS' strategic priorities within the Iowa HHS Medicaid Quality Strategy, and tie to national standardized performance measures that relate to dental services when available.
- As indicated in the Iowa HHS Medicaid Quality Strategy, HHS plans to contractually require that MCOs engage in two additional PIPs per year (two HSAG validated PIPs and two non-HSAG validated PIPs) that focus on prevention and care of acute and chronic conditions, high risk services, oral health, etc. As such, HSAG continues to recommend that HHS consider selecting the topics for the additional PIPs to ensure alignment with the Iowa HHS Quality Strategy goals and objectives. Additionally, HHS could also require specific interventions (e.g., active, innovative improvement strategies) that MCOs must implement for PIPs with the potential to directly impact the performance indicator outcomes and facilitate comparability among the MCOs.
- When mandating future non-clinical PIP topic areas, HHS could consider requiring the MCPs (i.e., the MCOs and the PAHPs) to design PIPs that address lower-performing member satisfaction survey results as identified through CAHPS and any HHS-mandated or PAHP-implemented dental experience survey. HHS could also require all MCPs to focus an intervention on increasing survey response rates.
- To improve MCP performance in the Grievance and Appeal program area assessed through the compliance review activity, and to ensure that member rights are not being impeded, HHS should consider developing model grievance, adverse benefit determination (ABD), and appeal notices that include all federal and state-specific requirements, as applicable.
- HSAG determined through the compliance review activity that most MCPs maintained a peer-to-peer (P2P) and reconsideration process in which the initial service authorization denial could be overturned by the same practitioner who issued the denial after receipt of additional information or information obtained during the P2P that occurred after issuance of the ABD notice but prior to the appeal process. HSAG recommends that HHS update contract language to ensure that MCPs' P2P processes do not conflict with Medicaid managed care requirements. HHS should also ensure that MCPs track all overturned denials that occur after an ABD is sent to the member through the appeal process, and MCPs obtain member consent when a provider appeals on the member's behalf as required by Medicaid managed care regulations.
- HSAG continues to recommend that HHS issue formal guidance to all MCPs, detailing its expectations for how the MCPs should assess appointment wait time standards and consider revisions to the survey protocol to ensure the MCPs' compliance with State standards are accurately measured. As CMS has implemented appointment timeliness standards effective in 2027, HHS should also ensure that these standards are incorporated into all MCP

Performance Impact on Strategic Priorities and Objectives	Performance Domain
contracts, as applicable. Specifically, to comply with the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F), HHS should implement the following within the required effective dates: – Review the maximum appointment wait times standards (i.e., 15 business days for routine primary care [adult and pediatric] and obstetric/gynecological services; 10 business days for outpatient mental health and substance use disorder [SUD] appointments). • HSAG also continues to recommend that HHS contract with an independent vendor to perform secret shopper surveys of MCP compliance with appointment wait times and accuracy of provider directories and require directory inaccuracies to be sent to HHS within three days of discovery, in accordance with CMS-2439-F. Results from the secret shopper survey will provide assurances to HHS that the MCPs' networks have the capacity to serve the expected enrollment in their service area and that they offer appropriate access to preventive and primary care services for their members. • To also ensure adherence to CMS-2439-F, HHS should confirm that an annual member experience survey for each MCP is conducted and analyze the responses to determine where opportunities for improvement exist and implement initiatives that target improvement. • To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), HHS should update the contracts with its MCPs within the required effective dates for each specific requirement as follows: – Require the MCPs to implement the payer-to-payer, provider access, and prior authorization application programming interfaces (APIs) to improve patient, provider, and payer access to patient data and reduce the burden of prior authorization processes.	

2. Overview of the Iowa Managed Care Program

Managed Care in Iowa

Since April 2016, most Medicaid recipients in Iowa receive benefits through a CMS-approved section 1915(b) waiver program called the Iowa High Quality Healthcare Initiative (Initiative). The Initiative also includes §1915(c) waiver and §1115 demonstration recipients and operates statewide. MCOs are contracted by HHS to deliver all medically necessary, Medicaid-covered physical health, behavioral health, and LTSS benefits in a highly coordinated manner. HHS also contracts with PAHPs to deliver dental benefits to members enrolled in the DWP and Hawki program.[4]

Overview of Managed Care Plans (MCPs)

During the CY 2025 review period, HHS contracted with three MCOs and two PAHPs. These MCPs are responsible for the provision of services to Iowa Medicaid and Hawki members. Table 2-1 provides a profile for each MCP.

Table 2-1—MCP Profiles

MCOs	Total Enrollment[5]	Covered Services[6]	Service Area
ITC	218,840	• Preventive Services • Professional Office Services • Inpatient Hospital Admissions • Inpatient Hospital Services • Outpatient Hospital Services • Emergency Care • Behavioral Health Services • Outpatient Therapy Services • Prescription Drug Coverage • Radiology Services • Laboratory Services • Durable Medical Equipment (DME) • LTSS—Community Based • LTSS—Institutional • Hospice • Health Homes	Statewide
MOL	193,537		
WLP	239,393		

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

[5] Iowa Department of Health and Human Services, Iowa Medicaid. Enrollment data provided by HHS on Feb 25, 2026.

[6] Iowa Department of Human Services. *Comparison of Medicaid Basic Benefits Based on Eligibility Determination.* Rev. 8/25. Available at: https://hhs.iowa.gov/sites/default/files/Comm519.pdf?092720211503. Accessed on: Jan 27, 2026.

PAHPs[3]	Total Enrollment[7]	Covered Services[8,9]	Service Area
DDIA	452,992	• Diagnostic and Preventive Services (exams, cleanings, x-rays, and fluoride) • Fillings for Cavities • Surgical and Non-Surgical Gum Treatment • Root Canals • Dentures and Crowns • Extractions • Medically necessary orthodontics (covered service for Hawki only)	Statewide
MCNA	207,404		

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

Table 2-2—MCP Enrollment by Population[10]

MCP		Enrollment Population	Enrollment Count	Total Enrollment
MCOs	ITC	Medicaid	197,800	**651,770**
		Hawki	21,040	
		Total	**218,840**	
	MOL	Medicaid	174,122	
		Hawki	19,415	
		Total	**193,537**	
	WLP	Medicaid	217,677	
		Hawki	21,716	
		Total	**239,393**	
PAHPs	DDIA	DWP Adults	209,973	**660,396**
		DWP Kids	177,954	
		Hawki	65,065	
		Total	**452,992**	
	MCNA	DWP Adults	119,000	
		DWP Kids	88,404	
		Hawki	NA*	
		Total	**207,404**	

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

[7] Iowa Department of Health and Human Services, Iowa Medicaid. Enrollment data provided by HHS on Feb 25, 2026.
[8] State of Iowa Department of Health and Human Services. Dental Wellness Plan. Available at: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/dental-wellness-plan. Accessed on: Jan 27, 2026.
[9] State of Iowa Department of Health and Human Services. Hawki. Available at: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki-chip. Accessed on: Jan 27, 2026.
[10] Iowa Department of Health and Human Services, Iowa Medicaid. Enrollment data provided by HHS on Feb 25, 2026.

Quality Strategy

The Iowa HHS Medicaid Quality Strategy[11] outlines HHS' strategy for promoting policy and action to effectively improve the Medicaid program. Activities within the Iowa HHS Medicaid Quality Strategy are directed toward outcomes that create healthier members through the development of systems and practices that promote quality and sustainability. Table 2-3 presents the Iowa HHS Medicaid Quality Strategy strategic priorities and key goals for completion by SFY 2027.

Table 2-3—Iowa HHS Medicaid Quality Strategy

Strategic Priority	Goals
1.0 Access to Care	• HHS will work collaboratively with the MCOs and Directed Payments to complete the following projects to completion. – HHS will complete a project to enhance access to behavioral health services for children with complex behavioral health needs. – HHS will complete a comprehensive project around access to care for high-risk pregnancies. – HHS will complete a comprehensive project to address access to primary, specialty and dental 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. • Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last Calendar year.
2.0 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%. • HHS will increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80%. • HHS will increase Initiation and Engagement of Substance Use Disorder All 10 Treatment (IET-AD) from 39.2% to 45% for initiation and from 15.5% to 20% for engagement. • HHS will increase prenatal visits in the first trimester by 5% (59%). • HHS will increase Postpartum visits from 5% (32%). • 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%.

[11] Iowa Department of Human Services. Iowa HHS Medicaid Quality Strategy, July 2024. Available at: https://hhs.iowa.gov/media/14254/download?inline. Accessed on: Jan 27, 2026.

Strategic Priority	Goals
3.0 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
4.0 Program Administration	• HHS will complete a comprehensive project around Grievance, Appeals, and Exception to Policy. • Iowa Medicaid will complete a project that works toward integration between the medical and dental programs.
5.0 Voice of the Customer	HHS will complete a comprehensive project around the voice of the customer.

Quality Initiatives

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

Medicaid Enterprise Modernization Effort (MEME) Program: The MEME program continued in 2025. This large, multi-year information technology (IT) systems and business process modernization effort is focused on achieving outcomes that align with the Medicaid strategic priorities. Focusing on measurable outcomes (e.g., shortening the time required to approve an application) can generate dramatically improved results compared to requirements-based IT procurement approaches from the past. This also aligns with CMS' move to streamline modular certification that likewise shifts to an outcomes-based mindset. Iowa is actively implementing a module to deliver a modernized enrollment process for providers as well as improve data quality to analyze the provider network.

Two additional large projects are well into planning, including an assessment of IT modifications necessary to support a waiver redesign that will transition Iowa from a diagnosis-based approach to Home- and Community-Based Services (HCBS) to a streamlined, needs-oriented approach beginning sometime in 2026. Finally, a Quality Management System (QMS) is being developed to deliver better insight into Medicaid (and related) data sets focusing on metrics derived from a member-journey perspective that will help guide strategic decision making and oversight of delivery of care.

To learn more about MEME, please visit the following link: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/current-projects/meme.

Iowa REACH (Responsive, Effective, Accessible, Child & Family-centered Health) Initiative: This initiative represents a groundbreaking effort by Iowa HHS to address critical gaps in the mental and behavioral health system for Medicaid-eligible children and youth.

Launched in response to a federal lawsuit (*C.A. v. Garcia*), REACH serves as a model of systemic reform and accountability. It aims to build a child- and family-centered system that delivers timely, equitable, and individualized care for children and youth who are Medicaid eligible, have been diagnosed with serious emotional disturbance, and have been assessed to need intensive in-home and community therapeutic services.

Key highlights of the initiative:

- Court-Monitored Implementation: Overseen by a dedicated Implementation Team, along with a Consumer Steering Committee and subcommittees, to ensure transparency, accountability, and progress tracking.
- Guiding principles:
  - *Child-Centered and Family-Driven*: Active family involvement in planning, delivery, and evaluation of services.
  - *Team-Based and Collaborative*: Cross-system coordination for integrated care.
  - *Home and Community-Based*: Emphasis on inclusive, least-restrictive environments.

- *Natural Supports*: Strength-based focus, leveraging family and community networks.
- *Culturally Responsive and Individualized*: Services tailored to each family's unique needs.
- *Outcome-Focused*: Commitment to flexible, goal-driven, and unconditional care to ensure sustainable impact.

In 2026, Iowa HHS is dedicated to identifying and outlining the services for REACH, along with designing a draft provider manual and other supportive documents while collaborating with the Implementation Team and other subcommittees.

The REACH Initiative exemplifies a best-practice model in system transformation and demonstrates how meaningful stakeholder engagement and structured oversight can lead to lasting improvements in service quality and health equity for vulnerable populations.

To learn more about REACH, please visit the following link: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/current-projects/iowa-reach.

HOME (Hope and Opportunity in Many Environments): The HOME initiative is a multi-year effort by Iowa HHS to strengthen and modernize the State's system of behavioral health, disability, and aging services, with a focus on improving access to high-quality, community-based care.

The project began in 2022 and 2023 with a comprehensive evaluation of Iowa's HCBS system, including extensive input from members, caregivers, advocates, and providers to identify priority areas for improvement. In 2024, Iowa HHS implemented standardized case management training and reduced caseloads to allow case managers to spend more time supporting members.

Building on this work, in 2025 Iowa HHS submitted amendments to its HCBS waivers, effective January 2026. Key changes include shifting assessments from managed care organizations to an independent assessor and streamlining services by combining similar offerings to improve access and better align services with member needs.

In 2026, the State will begin transitioning members from several existing waivers—including Children's Mental Health, Health and Disability, Physical Disability, and AIDS/HIV—into the new HOME waivers: Adults with Disabilities and Children and Youth. These waivers will also expand to serve individuals with developmental disabilities and autism.

Looking ahead to 2027 and beyond, Iowa HHS plans to transition members from the Intellectual Disability and Brain Injury waivers into the HOME structure and further enhance services by adding Supported Community Living, Residential-Based Supported Community Living, Day Habilitation, and Enabling Technology for Remote Supports.

To learn more about HOME, please visit the following link: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/current-projects/home.

Certified Community Behavioral Health Clinics (CCBHCs): In 2023, Iowa HHS was awarded a one year, $1 million planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the design and implementation of an Iowa CCBHCs program.

On June 4, 2024, SAMHSA announced that Iowa was one of 10 states selected to join the new cohort of CCBHCs for 2025. The Demonstration is a four-year program.

CCBHCs are specialty clinics that provide a comprehensive range of mental health and substance use services. CCBHCs are brick-and-mortar behavioral health safety net providers that are required to serve anyone who walks through their doors, regardless of age, diagnosis, insurance status, or place of residence. CCBHCs are required to coordinate nine core services.

Iowa currently has 10 CCBHC providers.

3. Assessment of Managed Care Organization Performance

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2025 review period to evaluate the performance of MCOs on providing quality, timely, and accessible healthcare services to Iowa Managed Care Program members. Quality, as it pertains to EQR, means the degree to which the MCOs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidence-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to HHS' network adequacy standards) and §438.206 (adherence to HHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the MCOs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in CY 2025 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A. Table 3-1 provides HSAG's timeline for conducting each of the EQR activities.

Table 3-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
PIPs	June 23, 2025	December 8, 2025
PMV	August 5, 2025	January 30, 2026

Activity	EQR Activity Start Date	EQR Activity End Date
Compliance Review	May 5, 2025	November 21, 2025
NAV	March 26, 2025	February 16, 2026
EDV	May 12, 2025	February 26, 2026
CAHPS	May 14, 2025	January 7, 2026
Scorecard	April 10, 2025	November 20, 2025

Validation of Performance Improvement Projects

For the CY 2025 validation, the MCOs continued two HHS-mandated PIP topics, *Social Determinants of Health (SDOH) Screening* and *Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication (ADD-HEDIS)*. HSAG conducted validation of the Design stage (Steps 1–6) and Implementation stage (Steps 7 and 8) for each PIP topic in accordance with the CMS EQR protocol for validation of PIPs (CMS EQR Protocol 1). Table 3-2 outlines the selected PIP topics and performance indicators for each MCO.

Table 3-2—PIP Topics and Performance Indicators

MCO	PIP Topic	Performance Indicator
ITC	*SDOH Screening*	The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.
		The percentage of existing enrolled members who received a subsequent screening for SDOH during the measurement period.
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	Follow-up care for children prescribed ADHD medication (ADD-E): Initiation phase.
		Follow-Up Care for Children Prescribed ADHD Medication (ADD-E): Continuation and Maintenance (CM) Phase.
MOL	*SDOH Screening*	Newly enrolled Medicaid: The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.
		Existing enrolled Medicaid: The percentage of existing members who received a subsequent screening for SDOH during the measurement period.
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	Initiation Phase: The percentage of the eligible population that had one follow-up visit during the 30-day initiation phase.
		Continuation and Maintenance Phase: The percentage of the eligible population who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

MCO	PIP Topic	Performance Indicator
WLP	*SDOH Screening*	The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.
		The percentage of existing enrolled members who received a subsequent screening for SDOH during the measurement period.
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	Members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.
		Members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

Performance Measure Validation

For the EQR time frame under evaluation, HSAG completed PMV activities for **WLP**, **ITC**, and **MOL** for measurement year (MY) 2024 (January 1, 2024–December 31, 2024) to validate enrollment and eligibility, claims and encounter, provider data processing, and data integration and validation procedures that contribute to CMS managed long-term services and supports (MLTSS) and Core Set reporting. HSAG also validated data integration and measure production processes of an HHS vendor, IBM Watson (IBM), which is contracted with HHS to provide aggregate performance measure rates for all Medicaid populations for CMS Core Set reporting.

Table 3-3 shows the list of CMS Core Set performance measures and measurement periods evaluated for MY 2024 for the CY 2025 PMV activity.

Table 3-3—CMS Core Set Performance Measures for Validation

Performance Measure Name and Indicator	Measure Source
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years	CMS Child Core Set
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	CMS Child Core Set
Antidepressant Medication Management	CMS Adult Core Set
Asthma Medication Ratio: Ages 5 to 18	CMS Child Core Set
Metabolic Monitoring for Children and Adolescents on Antipsychotics	CMS Child Core Set
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	CMS Child Core Set
Screening for Depression and Follow-Up Plan	CMS Adult Core Set
Chlamydia Screening in Women: Ages 16 to 20	CMS Child Core Set
Childhood Immunization Status	CMS Child Core Set

Performance Measure Name and Indicator	Measure Source
Developmental Screening in the First Three Years of Life	CMS Child Core Set
Follow-Up After Emergency Department Visit for Substance Use	CMS Adult Core Set
Follow-Up After Hospitalization for Mental Illness	CMS Adult Core Set
Follow-Up After Emergency Department Visit for Mental Illness	CMS Adult Core Set
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set
Initiation and Engagement of Substance Use Disorder Treatment	CMS Adult Core Set
Immunizations for Adolescents	CMS Child Core Set
Lead Screening in Children	CMS Child Core Set
Oral Evaluation, Dental Services	CMS Child Core Set
Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	CMS Adult Core Set
Sealant Receipt on Permanent First Molars	CMS Child Core Set
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	CMS Adult Core Set
Topical Fluoride for Children	CMS Child Core Set
Well-Child Visits in the First 30 Months	CMS Child Core Set
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	CMS Child Core Set
Child and Adolescent Well-Care Visits	CMS Child Core Set

Table 3-4 shows the list of CMS MLTSS performance measures and measurement periods evaluated for MY 2024 for the CY 2025 PMV activity.

Table 3-4—LTSS Performance Measures for Validation

Performance Measure Name	Acronym	Method	Required Specifications
Managed Long-Term Services and Supports Admission to a Facility from the Community	MLTSS-6	Admin	CMS LTSS
Managed Long-Term Services and Supports Minimizing Facility Length of Stay	MLTSS-7	Admin	CMS LTSS
Managed Long-Term Services and Supports Successful Transition after Long-Term Facility Stay	MLTSS-8	Admin	CMS LTSS

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

Table 3-5 shows the reported measures divided into performance measure domains of care.

Table 3-5—HEDIS Measures Reported by IA MCOs

HEDIS Measure by Domain of Care
Access to Preventive Care
Adults' Access to Preventive/Ambulatory Health Services
Ages 20–44 Years
Ages 45–64 Years
Ages 65 and Older
Use of Imaging Studies for Low Back Pain
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
BMI Percentile Documentation—Total
Counseling for Nutrition—Total
Counseling for Physical Activity—Total
Women's Health
Breast Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women—Total
Prenatal and Postpartum Care
Timeliness of Prenatal Care
Postpartum Care
Living With Illness
Glycemic Status Assessment for Patients With Diabetes
Glycemic Status (<8%)
Glycemic Status (>9.0%)
Blood Pressure Control for Patients With Diabetes
Blood Pressure Control (<140/90 mm Hg)
Eye Exam for Patients With Diabetes
Eye Exam (Retinal) Performed
Controlling High Blood Pressure
Statin Therapy for Patients With Cardiovascular Disease
Received Statin Therapy—Total
Statin Therapy for Patients With Diabetes
Received Statin Therapy

HEDIS Measure by Domain of Care
Behavioral Health
Diabetes Monitoring for People With Diabetes and Schizophrenia
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Follow-Up After Emergency Department (ED) Visit for Substance Use
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Follow-Up After ED Visit for Mental Illness
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Initiation and Engagement of Substance Use Disorder (SUD) Treatment
Initiation of SUD Treatment—Total
Engagement of SUD Treatment—Total
Metabolic Monitoring for Children and Adolescents on Antipsychotics
Blood Glucose and Cholesterol Testing—Total
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total
Keeping Kids Healthy
Childhood Immunization Status
Combination 3
Combination 10
Immunizations for Adolescents
Combination 1
Combination 2
Lead Screening in Children
Well-Child Visits in the First 30 Months of Life
Well-Child Visits in the First 15 Months
Well-Child Visits for Age 15 Months-30 Months
Child and Adolescent Well-Care Visits—Total
Medication Management
Statin Therapy for Patients With Cardiovascular Disease
Statin Adherence 80%—Total
Statin Therapy for Patients With Diabetes
Statin Adherence 80%—Total

HEDIS Measure by Domain of Care
Adherence to Antipsychotic Medications for Individuals With Schizophrenia
Antidepressant Medication Management
Effective Acute Phase Treatment
Effective Continuation Phase Treatment
Appropriate Testing for Pharyngitis—Total
Asthma Medication Ratio-Total
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
Initiation Phase
Continuation and Maintenance Phase
Appropriate Treatment for Upper Respiratory Infection—Total
Persistence of Beta-Blocker Treatment After a Heart Attack
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
Systemic Corticosteroid
Bronchodilator
Use of Opioids at High Dosage
Use of Opioids From Multiple Providers
Multiple Prescribers
Multiple Pharmacies
Multiple Prescribers and Multiple Pharmacies

Network Adequacy Validation

In CY 2025, HSAG conducted and completed NAV activities for three MCOs—**ITC**, **MOL**, and **WLP**.

States that contract with MCOs to provide Medicaid or CHIP services are required to develop quantitative network adequacy standards across a subset of provider types to set expectations for each contracted MCP's provider networks. States may elect to use a variety of quantitative standards including, but not limited to, minimum provider-to-member ratios, time and distance, percentage of providers accepting new patients, and/or combinations of these quantitative measures. Based on the state-defined network adequacy standards, the State and HSAG defined the network adequacy indicators, which HSAG then validated. The indicators are metrics used to assess adherence to the quantitative network adequacy standards required and set forth by the State. HHS identified network adequacy indicators to be validated for the reporting period(s) during CY 2025, with data reported as of December 31, 2024, for time and distance and minimum provider agreement standards and the most recent data collected since prior year NAV activities as of June 30, 2025, for appointment wait time standards. The results represent a snapshot in time, summarizing cumulative network adequacy data

collected over the preceding 12 months. Table 3-6 through Table 3-8 list the network adequacy standards and the indicators that HSAG validated.

Table 3-6—MCO Network Adequacy Indicators Validated—Time and Distance Standards

Network Category Description	Urban Area—Time and Distance Standard	Rural Area—Time and Distance Standard
Primary Care Physician (PCP)	30 minutes or 30 miles from the personal residences of members	
Specialty Care	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	
Specialty Care	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	
Hospitals*	Not to exceed 30 minutes or 30 miles	30 minutes or 30 miles
Long-Term Care Services—*Institutional Providers*	30 minutes or 30 miles	60 minutes or 60 miles
Long-Term Care Services—*HCBS [Home- and Community-Based Service] Providers***	At least two providers per county for each covered HCBS in the benefit package for each 1915(c) waiver	
Behavioral Health Services—*Outpatient Services*	30 minutes or 30 miles from the personal residence of members	
Behavioral Health Services—*Inpatient, Residential, Intensive Outpatient, and Partial Hospitalization*	60 minutes or 60 miles from the personal residence of members	90 minutes or 90 miles from the personal residence of members
General Optometry Services	30 minutes or 30 miles	30 minutes or 30 miles
Lab and X-Ray Services—*Clinical Laboratory Improvement Amendments (CLIA) certified lab provider*	30 minutes or 30 miles	
Pharmacies	At least two pharmacy providers 30 minutes or 30 miles from a member's residence in each county, excluding pharmacies participating in the Specialty Pharmacy Program	

*Hospitals: Transport time shall be the usual and customary, not to exceed 30 minutes or 30 miles, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions shall be justified and documented to the State on the basis of community standards.

**In the event a county has an insufficient number of providers licensed, certified, or available, the access standard shall be based on the community standard and shall be justified and documented to the State.

Table 3-7—MCO Network Adequacy Indicators Validated—Appointment Wait Time Standards

Provider Type	Appointment Wait Time
PCP	Not to exceed four to six weeks from the date of a patient's request for a routine appointment, within 48 hours for persistent symptoms and urgent within one day.
Specialty Care	Not to exceed 30 days for routine care or one day for urgent care for non-dual enrolled members.
Behavioral Health Services—*Emergency*	Members with emergency needs shall be seen or referred to an appropriate provider upon presentation at a service delivery site.
Behavioral Health Services—*Mobile Crisis*	Members in need of mobile crisis services shall receive services within one hour of presentation or request.
Behavioral Health Services—*Urgent*	Members with urgent non-emergency needs shall be seen or referred to an appropriate provider within one hour of presentation at a service delivery site or within 24 hours of telephone contact with the provider or the Contractor.
Behavioral Health Services—*Persistent Symptoms*	Members with persistent symptoms shall be seen or referred to an appropriate provider within 48 hours or reporting symptoms.
Behavioral Health Services—*Routine*	Members with the need for routine services shall be seen or referred to an appropriate provider within three weeks of the request for an appointment.
Behavioral Health Services—*Substance Use Disorder & Pregnancy*	Members who are pregnant women in need of routine substance use disorder services must be admitted within 48 hours of seeking treatment.
Behavioral Health Services—*Intravenous Drug Use*	Members who are intravenous drug users must be admitted not later than 14 days after making the request for admission, or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request.
Emergency Care	All emergency care is immediate, at the nearest facility available, regardless of whether the facility or provider is under contract with the Contractor.
General Optometry Services	Not to exceed three weeks for regular appointments and 48 hours for urgent care.
Lab and X-Ray Services	Not to exceed three weeks for regular appointments and 48 hours for urgent care.

Table 3-8—MCO Network Adequacy Indicators Validated—Minimum Provider Agreements With Specialty Practicing Providers

Provider Type*
Allergy
Cardiology
Dermatology
Endocrinology
Gastroenterology
General Surgery
Hematology
Neonatology
Nephrology
Neurology
Obstetrics and Gynecology (OB/GYN)
Occupational Therapy
Oncology
Ophthalmology
Orthopedics
Otolaryngology
Pathology
Physical Therapy
Pulmonology
Psychiatry
Radiology
Reconstructive Surgery
Rheumatology
Speech Therapy
Urology
Pediatric Specialties

*At least one provider who meets access standards for the percentage of members in the access standard.

Encounter Data Validation

In CY 2025, HSAG conducted and completed one or both of these EDV activities for the three MCOs (i.e., **ITC**, **MOL**, and **WLP**). The EDV activities included:

- **Medical Record Review (MRR)**—Assessed the completeness and accuracy of HHS' electronic encounter data through a comparison with the corresponding members' medical records. The goal of this activity was to validate encounter data using medical records as the source of truth.
- **Comparative analysis**—Assessed the completeness and accuracy of HHS' electronic encounter data through a comparison between HHS' electronic encounter data and the data extracted from the MCOs' data systems. The goal of this activity was to evaluate the extent to which the encounter data submitted by the MCOs to HHS were complete and accurate.

For **MOL**, HSAG previously conducted a comparative analysis during the prior year; however, the evaluation was limited to four months of data because **MOL** did not begin serving Iowa Medicaid managed care members until July 1, 2023. In the current EDV cycle, HSAG conducted a more comprehensive comparative analysis using a full year of data. This expanded scope allowed for a more complete assessment of trends and potential areas for improvement as **MOL** continues to integrate into the Iowa Medicaid program.

Table 3-9 lists the MCO names and abbreviations, along with the specific CY 2025 evaluation activities that were conducted for each of the MCOs.

Table 3-9—List of MCOs and Core Evaluation Activities

Calendar Year	MCO	Core Activity	Study Review Period*
CY 2025	**ITC**	MRR	July 1, 2023–June 30, 2024
	MOL	Comparative Analysis	November 1, 2023–October 31, 2024
		MRR	July 1, 2023–June 30, 2024
	WLP	MRR	July 1, 2023–June 30, 2024

Consumer Assessment of Healthcare Providers and Systems Analysis

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. Three MCOs, **ITC**, **MOL**, and **WLP**, were responsible for obtaining CAHPS vendors to administer the CAHPS surveys on the MCOs' behalf. HSAG presents top-box scores, which indicate the percentage of members who responded to the survey with positive experiences in a particular aspect of their healthcare. Table 3-10 displays the various measures of member experience.

Table 3-10—CAHPS Measures of Member Experience

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

Scorecard

HSAG analyzed MY 2024 HEDIS results and MY 2024 CAHPS data from the three MCOs (**ITC**, **MOL**, and **WLP**) for presentation in the 2025 Iowa Medicaid Scorecard. MCO performance was evaluated in the following six reporting categories identified as important to consumers:

- **Doctors' Communication and Patient Engagement:** This category includes adult and child CAHPS composites and HEDIS measures related to patient satisfaction with providers and patient engagement.
- **Access to Preventive Care:** This category consists of CAHPS composites and HEDIS measures related to adults' and children's access to preventive care.
- **Women's Health:** This category consists of HEDIS measures related to screenings for women and maternal health.

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

HSAG computed six reporting category summary scores and 15 subcategory summary scores for each MCO, compared each measure to national benchmarks, and assigned star ratings for each measure.

External Quality Review Activity Results

Iowa Total Care, Inc.

Validation of Performance Improvement Projects

Performance Results

HASG's validation evaluated the technical methods of ITC's PIP (i.e., the PIP Design and Implementation stage). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-11 displays the validation ratings and performance indicators.

Table 3-11—Overall Validation Rating for ITC

PIP Topic	Validation Rating 1*	Validation Rating 2**	Performance Indicator	Performance Indicator Results		
				Baseline	R1	R2
Nonclinical PIP: *SDOH Screening*	*High Confidence*	*Not Assessed*	The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.	91.9%	—	—
			The percentage of existing enrolled members who received a subsequent screening for SDOH during the measurement period.	43.8%	—	—
Clinical PIP: *Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)*	*High Confidence*	*Not Assessed*	Follow-up care for children prescribed ADHD medication (ADD-E): Initiation phase.	54.7%	—	—
			Follow-Up Care for Children Prescribed ADHD Medication (ADD-E): Continuation and Maintenance (CM) Phase.	62.5%	—	—

Validation Rating 1 = Overall confidence of adherence to acceptable methodology for all phases of the PIP.
Validation Rating 2 = Overall confidence that the PIP achieved significant improvement.
R1 = Remeasurement 1
R2 = Remeasurement 2
Gray shading with a dash (—) = The PIP had not progressed to reporting R1, or R2 results during SFY 2025.
* Based on the scores assigned for individual evaluation elements in the PIP Validation Tool and the confidence level definitions provided in Appendix A.
** Not Assessed—HSAG did not assess Validation Rating 2 for CY 2025 as the MCO reported the Design and Implementation stage for each PIP.

The goal for both PIPs is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Table 3-12 displays the barriers identified through quality improvement (QI) and

causal/barrier analysis processes and the interventions initiated by the MCO to support achievement of the PIP goals and address the barriers.

Table 3-12—Barriers and Interventions for ITC

SDOH Screening	
Barriers	**Interventions**
Limited health plan education about the need to complete health risk screening (HRS).	Text message outreach and education on HRS.
Lack of access to internet and/or phone services.	HRS included in Mobex pilot.
Limited member access, knowledge, and understanding of HRS.	HRS at Green to Go community events.
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	
Barriers	**Interventions**
Limited member knowledge about the need for a 30-day follow-up visit.	Text message outreach to eligible members during the initiation phase of the ADD HEDIS measure.
Lack of health plan outreach and education to members on the need for follow-up visits after new ADHD medication prescription.	Mail outreach reminders to eligible members during the continuation and maintenance phase.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: ITC created sound PIP designs and has the foundation to progress to subsequent PIP stages. [**Quality**]

Strength #2: ITC used appropriate QI tools to identify barriers to care and developed interventions that can reasonably impact the performance indicators. [**Quality**]

Weaknesses and Recommendations

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

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends that **ITC** evaluate the effectiveness of each intervention effort to determine its impact and guide decisions on next steps.

Performance Measure Validation

Performance Results

PMV

HSAG reviewed ITC's eligibility and enrollment data system, claims and encounter data processing system, provider data system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, ITC demonstrated it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report accurate encounter data and performance measure rates to HHS. However, during the audit HSAG identified misalignments between ITC's source code and the technical specifications. ITC corrected its source code during the audit and submitted updated member-level detail files for specification alignment. All records reviewed aligned with the data output files and the technical specifications for performance measure calculation. ITC was able to report valid and reportable rates. Table 3-13 displays the indicator rates for each performance measure reported by ITC.

Table 3-13—ITC MY 2024 MLTSS Performance Measures

	LTSS Performance Measures	Denominator	Numerator	Performance Measure Rate
Medicaid MLTSS Admission to a Facility from the Community (MLTSS-6)				
1.	*Short-Term Stay—18–64 Years*	58,867	54	0.92
	Short-Term Stay—65–74 Years	21,434	77	3.59
	Short-Term Stay—75–84 Years	14,077	56	3.98
	Short-Term Stay—85+ Years	7,830	25	3.19
	Medium-Term Stay—18–64 Years	58,867	100	1.70
	Medium-Term Stay—65–74 Years	21,434	137	6.39
	Medium-Term Stay—75–84 Years	14,077	115	8.17
	Medium-Term Stay—85+ Years	7,830	65	8.30
	Long-Term Stay—18–64 Years	58,867	257	4.37
	Long-Term Stay—65–74 Years	21,434	294	13.72
	Long-Term Stay—75–84 Years	14,077	282	20.03
	Long-Term Stay—85+ Years	7,830	270	34.48
Medicaid MLTSS Minimizing Facility Length of Stay (MLTSS-7)				
2.	*Observed Rate*	1,481	194	13.10%
	Risk-Adjusted Rate	1,481	345.4200	23.32%
	O/E Ratio	345.4200	194	0.5616

LTSS Performance Measures		Denominator	Numerator	Performance Measure Rate
Medicaid MLTSS Successful Transition After Long-Term Facility Stay (MLTSS-8)				
3.	*Observed Rate*	668	92	13.77%
	Risk-Adjusted Rate	668	397.7800	59.55%
	O/E Ratio	397.7800	92	0.2313

HEDIS

HSAG's review of the Final Audit Report (FAR) for HEDIS MY 2024 showed that **ITC**'s HEDIS compliance auditor found **ITC**'s information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. **ITC** contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. Table 3-14 displays the indicator rates for each HEDIS MY 2024 performance measure reported by **ITC**.

Table 3-14—HEDIS MY 2024 Results for ITC

Measures	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Three-Year Trend	Star Rating
Access to Preventive Care					
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	77.46%	80.15%	80.97%	↑	★★★★
45–64 Years	83.91%	84.84%	86.57%	↑	★★★
65+ Years	84.62%	85.51%	83.88%	↓	★★★
Use of Imaging Studies for Low Back Pain					
Total	68.75%	65.46%	65.11%	↓	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI percentile—Total	70.07%	79.56%	84.67%	↑	★★★
Counseling for Nutrition—Total	58.39%	65.94%	69.34%	↑	★★
Counseling for Physical Activity—Total	54.01%	62.04%	63.02%	↑	★★
Women's Health					
Breast Cancer Screening					
Breast Cancer Screening	NR	53.98%	56.57%	—	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	—	52.36%	55.50%	—	★★★
Chlamydia Screening in Women					
Total	47.89%	47.38%	44.21%	↓	★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	81.75%	86.13%	89.78%	↑	★★★★

Measures	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Three-Year Trend	Star Rating
Postpartum Care	77.86%	82.48%	86.62%	↑	★★★★
Living With Illness					
Glycemic Status Assessment for Patients With Diabetes					
Glycemic Status <8.0%	48.42%	56.45%	63.50%	↑	★★★
*Glycemic Status >9.0%**	41.61%	31.14%	28.47%	↑	★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	69.10%	72.99%	79.32%	↑	★★★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	56.69%	56.45%	62.29%	↑	★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	61.07%	69.83%	75.67%	↑	★★★★★
Statin Therapy for Patients With Cardiovascular Disease					
Received Statin Therapy—Total	69.03%	79.94%	80.04%	↑	★★
Statin Therapy for Patients With Diabetes					
Received Statin Therapy	56.09%	63.67%	63.26%	↑	★★
Behavioral Health					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	58.06%	68.91%	70.94%	↑	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.59%	78.33%	83.36%	↑	★★★
Follow-Up After Emergency Department Visit for Substance Use					
7-Day Follow-Up—Total	56.74%	58.66%	41.16%	↓	★★★★★
30-Day Follow-Up—Total	66.30%	67.87%	54.90%	↓	★★★★★
Follow-Up After Emergency Department Visit for Mental Illness					
7-Day Follow-Up—Total	63.69%	66.11%	62.06%	↓	★★★★★
30-Day Follow-Up—Total	75.03%	77.70%	75.47%	↑	★★★★★
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	52.84%	57.71%	67.09%	↑	★★★★★
30-Day Follow-Up—Total	71.37%	75.84%	80.94%	↑	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment					
Initiation of SUD Treatment—Total	58.37%	45.26%	54.18%	↓	★★★★
Engagement of SUD Treatment—Total	20.94%	16.62%	20.11%	↓	★★★★

Measures	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Three-Year Trend	Star Rating
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose and Cholesterol Testing—Total	NR	27.81%	26.70%	—	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	61.74%	61.64%	64.47%	↑	★★★
Keeping Kids Healthy					
Childhood Immunization Status					
Combination 3	74.94%	72.26%	74.21%	↓	★★★★
Combination 10	45.50%	40.88%	36.98%	↓	★★★★
Immunizations for Adolescents					
Combination 1	84.43%	85.88%	90.27%	↑	★★★★★
Combination 2	34.31%	30.54%	33.58%	↓	★★
Lead Screening in Children					
Lead Screening in Children	74.93%	74.68%	79.15%	↑	★★★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	66.01%	67.23%	69.87%	↑	★★★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	70.70%	72.93%	75.56%	↑	★★★
Child and Adolescent Well-Care Visits					
Total	50.54%	55.17%	58.65%	↑	★★★
Medication Management					
Statin Therapy for Patients With Cardiovascular Disease					
Statin Adherence 80%—Total	68.79%	62.43%	65.45%	↓	★
Statin Therapy for Patients With Diabetes					
Statin Adherence 80%	67.79%	62.11%	64.70%	↓	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	59.99%	61.98%	65.81%	↑	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	60.82%	63.35%	56.26%	↓	★
Effective Continuation Phase Treatment	42.60%	43.91%	40.03%	↓	★
Appropriate Testing for Pharyngitis					
Total	80.05%	86.89%	87.45%	↑	★★★
Asthma Medication Ratio					
Total	65.87%	65.50%	64.90%	↓	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Total	59.55%	57.82%	57.00%	↓	★★

Measures	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Three-Year Trend	Star Rating
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	NR	54.92%	54.70%	—	★★★★
Continuation and Maintenance Phase	NR	60.79%	62.52%	—	★★★★
Appropriate Treatment for Upper Respiratory Infection					
Total	89.90%	87.97%	88.72%	↓	★★
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	75.14%	58.67%	49.06%	↓	★
Pharmacotherapy Management of COPD Exacerbation					
Bronchodilator	74.97%	83.82%	77.97%	↑	★
Systemic Corticosteroid	69.01%	73.45%	69.59%	↑	★★
Use of Opioids at High Dosage*					
Use of Opioids at High Dosage	1.88%	1.37%	1.27%	↑	★★★★
Use of Opioids From Multiple Providers*					
Multiple Pharmacies	1.63%	2.42%	2.62%	↓	★★
Multiple Prescribers	17.07%	20.24%	18.89%	↓	★★★
Multiple Prescribers and Multiple Pharmacies	1.16%	1.74%	1.81%	↓	★★

* For this indicator, a lower rate indicates better performance.
—This symbol indicates that NCQA recommended a break in trending; therefore, the rate is not displayed.
"NR" indicates that measure rate was not reported.
↓ Indicates performance worsened over a three-year time period.
↑ Indicates performance improved over a three-year time period.
HEDIS MY 2024 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★ = At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★= Below the 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: ITC's performance in the Keeping Kids Healthy domain remained strong in several areas. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits, Childhood Immunization Status—Combination 3* and

Combination 10, and *Lead Screening in Children* indicator rates finished at or above the 75th percentile. Further, the *Immunizations for Adolescents—Combination 1* indicator rate finished at or above the 90th percentile. [**Quality** and **Access**]

Strength #2: ITC's performance in the Behavioral Health domain remained strong for the *Follow-Up After Emergency Department Visit for Substance Use*, *Follow-Up After Emergency Department Visit for Mental Illness,* and *Follow-Up After Hospitalization for Mental Illness* measures, with all measure indicators finishing at or above the 90th percentile. In addition, *Initiation and Engagement of Substance Use Disorder Treatment* measure indicators finished at or above the 75th percentile. [**Quality**, **Timeliness**, and **Access**]

Strength #3: ITC's performance in the Living with Illness domain improved for the *Controlling High Blood Pressure* and *Blood Pressure Control for Patients With Diabetes* measures, with both measure indicators finishing at or above the 90th percentile. [**Quality** and **Timeliness**]

Strength #4: Within the Women's Health domain, **ITC**'s performance for the *Prenatal and Postpartum Care* measure indicators demonstrated a rate increase, finishing at or above the 75th percentile. [**Quality**, **Timeliness**, and **Access**]

Strength #5: ITC demonstrated adequate systems and processes to receive and process enrollment/eligibility data and claims and encounter data prior to ingestion into its Enterprise Data Warehouse (EDW). **ITC** also demonstrated multiple methods of validation to ensure the accuracy and completeness of its data in the EDW. [**Quality**]

Strength #6: ITC demonstrated thorough knowledge and understanding of the MLTSS specifications and intent of each measure, and was able to identify and proactively update its source code to correct for a few specification misalignments identified during its internal primary source verification (PSV) investigation. [**Quality**]

Weaknesses and Recommendations

Weakness #1: ITC's performance in the Access to Preventive Care Domain remained low for the *Use of Imaging Studies for Low Back Pain* measure, which ranked below the 25th percentile. [**Quality**]

Why the weakness exists: Low rates indicate a high number of Iowa Medicaid members with a principal diagnosis of low back pain had imaging performed that was not essential in improving outcomes, while also causing unnecessary radiation exposure and accrued cost. Clinical guidelines strongly recommend against the use of imaging in the absence of indications of serious underlying pathology).[12]

Recommendation: ITC reported several initiatives to improve performance, including identifying and educating providers whose imaging practices were outside Clinical Practice Guidelines, promoting conservative treatment, and utilizing Quality Practice Advisors to provide ongoing quality

[12] Use of Imaging Studies for Low Back Pain (LBP) - NCQA. Accessed on: January 29, 2026.

engagement. HSAG recommends that **ITC** continue these interventions, as well as consider other quality interventions that have been shown to improve appropriate imaging studies for low back pain, including specific imaging prompts in the electronic medical record (EMR) and quality scorecards for providers.

Weakness #2: ITC's performance in the Behavioral Health domain continued to rank below the 25th percentile for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Diabetes Monitoring for Blood Glucose and Cholesterol Testing—Total*. Addressing the physical health needs of members diagnosed with mental health conditions is an important way to improve overall health, quality of life, and economic outcomes. Additionally, monitoring of blood glucose and cholesterol testing are important components of ensuring appropriate management of children and adolescents on antipsychotic medications. [**Quality**]

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

Recommendation: ITC reported several initiatives to improve performance, including provider and member education, behavioral health provider incentives, member engagement via text messaging, and direct support for noncompliant members by distributing test kits to noncompliant members ages 12 years and older. HSAG recommends that **ITC** continue these interventions, and where possible, identify and measure their effectiveness.

Weakness #3: During the virtual review, **ITC** indicated that its vendor encounter files were received and validated for Health Insurance Portability and Accountability Act (HIPAA) compliance prior to submitting the files to HHS. However, **ITC** relied upon its vendors for encounter data accuracy, and therefore, did not ingest the encounter files into its encounter data management (EDM) system to conduct additional post-adjudication scrubs. [**Quality**]

Why the weakness exists: ITC relied on vendor-provided data for accuracy and did not incorporate encounter files into its internal systems for supplemental post-adjudication validation.

Recommendation: As a best practice, HSAG recommends that **ITC** work toward ingesting all vendor encounter files into the EDM to conduct additional post-adjudication scrubs, which would provide an additional level of validation to ensure the accuracy and completeness of all encounter data submitted to HHS.

Weakness #4: ITC confirmed that multiple facility stays were not included in its measure calculations, as the billed UB codes did not align with the required MLTSS measures value sets. **ITC** confirmed that the billed Uniform Billing (UB) codes aligned with HHS' billable codes, per HHS' *Informational Letter 2601-MC-FFS Revenue Code Billing for Managed Care Organization (MCO) Claims* and UB claim form instructions. [**Quality**]

Why the weakness exists: ITC has not explored the potential use of codes not included in the measure value set by mapping to allowable value set codes.

Recommendation: HSAG suggests that **ITC** consult with HHS to understand whether any of the billable codes not included in the MLTSS measures value set can be accurately mapped to the allowable value set codes for future audits. HSAG also recommends that **ITC** work in conjunction with its contracted facilities to provide insight regarding codes within the MLTSS measures value set and ensure billed codes accurately represent the code subcategory for facility stays of each member.

Compliance Review

Performance Results

Table 3-15 presents an overview of the results of the standards reviewed during the CY 2025 compliance review for **ITC**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **ITC** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-15—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	20	20	19	1	0	**95%**
Standard IX—Confidentiality	21	21	20	1	0	**95%**
Standard X—Grievance and Appeal Systems	38	38	35	3	0	**92%**
Standard XI—Subcontractual Relationships and Delegation	7	7	6	1	0	**86%**
Standard XII—Practice Guidelines	6	6	6	0	0	**100%**
Standard XIII—Health Information Systems	9	9	8	1	0	**89%**
Standard XIV—Quality Assessment and Performance Improvement Program	19	19	19	0	0	**100%**
Total	**120**	**120**	**113**	**7**	**0**	**94%**

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

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

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

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

Based on the findings from the CY 2025 compliance review activity, **ITC** was required to develop and submit a corrective action plan (CAP) for each element assigned a score of *Not Met*. The CAP was reviewed by HHS and HSAG for sufficiency, and **ITC** was responsible for implementing each action plan in a timely manner.

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Strength #2: ITC achieved full compliance for the Quality Assessment and Performance Improvement Program area, demonstrating that the MCO had adequate procedures and processes in place to support the provision of quality services to its members, maintain sufficient quality monitoring activities to assess ongoing performance, and conduct timely implementation of strategies to mitigate identified opportunities for improvement. [**Quality**]

Weaknesses and Recommendations

Weakness #1: ITC had three elements in the Grievances and Appeals program area that received a score of *Not Met*, indicating that the MCO had not implemented a member grievance and appeal process in accordance with all federal and/or contractual requirements. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Through a review of written policies and procedures and case files, gaps in **ITC**'s processes were identified related to timely resolution of appeals, oral notice of an expedited appeal resolution, and timely reinstatement of services.

Recommendation: While **ITC** was required to develop a CAP to address the identified deficiencies, HSAG recommends that the MCO enhance oversight and monitoring of its grievance and appeal processes by conducting a comprehensive review of a random sample of grievances and appeal files and implement corrective action for all identified deficiencies.

Network Adequacy Validation

Performance Results

Based on the results of the Information Systems Capability Assessment (ISCA) combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MCO according to the CMS EQR Protocol 4 and as defined in Table A-11 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 3-16 presents a summary of the NAV validation ratings for **ITC** by network adequacy standard type.

Table 3-16—Summary of ITC Validation Ratings by Standard Type

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias	Could Not Be Validated
Time/Distance	100%	0%	0%	0%	0%
Minimum Provider Agreements	100%	0%	0%	0%	0%
Appointment Wait Time	0%	0%	0%	0%	100%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 53 indicators for **ITC**. All 15 Time/Distance indicators received a rating of *High Confidence,* all 26 Minimum Provider Agreements received a rating of *High Confidence,* and the remaining 12 Appointment Wait Time indicators received a rating of *Could Not Be Validated*.

HSAG assessed results submitted by **ITC** that included data reported as of December 31, 2024, representing a snapshot in time and summarizing cumulative network adequacy data collected over the preceding 12 months, and that indicated compliance with the network adequacy time and distance standards for MCOs. Table 3-17 summarizes the percentage of members with access to the time and distance network adequacy indicators for the most recent available results during the reporting period. The compliance threshold for PCP, General Optometry, Lab and X-ray Services, and Pharmacies is 100 percent. The compliance threshold for Specialty Care Providers is access for at least 75 percent of members within 60 minutes or 60 miles and access for at least 99.5 percent of members within 90 minutes or 90 miles. The compliance threshold for Hospitals is 99.5 percent. Results that achieved the required percent threshold are shaded green and marked with a plus sign.

Table 3-17—ITC Q2 Percentage of Members With Access Across Time and Distance Indicators

Provider Type	Indicator	Percentage of Members With Access
PCP—Adult	30 minutes or 30 miles from the personal residences of members	100%+
PCP—Pediatric	30 minutes or 30 miles from the personal residences of members	100%+
Allergy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.9%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Allergy—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.9%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Cardiology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Cardiology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Dermatology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
Dermatology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Endocrinology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	98.5%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Endocrinology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.4%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Gastroenterology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.9%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Gastroenterology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.9%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
General Surgery—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
General Surgery—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Hematology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Hematology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Long-Term Care Services—*Institutional Providers:* ICF/ID—Individuals with Intellectual Disabilities—Urban	30 minutes or 30 miles	98.5%
Long-Term Care Services—*Institutional Providers*: ICF/ID—Individuals with Intellectual Disabilities—Rural	60 minutes or 60 miles	100%+
Long-Term Care Services—*Institutional Providers*: ICF/SNF—Skilled Nursing Care Facility—Urban	30 minutes or 30 miles	100%+
Long-Term Care Services—*Institutional Providers*: ICF/SNF—Skilled Nursing Care Facility—Rural	60 minutes or 60 miles	100%+

Provider Type	Indicator	Percentage of Members With Access
Neonatology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.0%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Nephrology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Nephrology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Neurology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Neurology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Neurosurgery—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.9%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
OB/GYN—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Occupational Therapy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Oncology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Oncology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Ophthalmology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.9%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Ophthalmology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.9%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
Orthopedics—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Orthopedics—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Otolaryngology (ENT)—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Otolaryngology (ENT)—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Pathology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Physical Therapy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
Psychiatry—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Pulmonology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Pulmonology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Radiology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Reconstructive Surgery—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	96.1%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Rheumatology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.9%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
Rheumatology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.9%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Speech Therapy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.9%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Urology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Urology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Hospital	30 minutes or 30 miles	99.9%+
Behavioral Health—Inpatient—Rural	90 minutes or 90 miles from the personal residence of members	100%+
Behavioral Health—Inpatient—Urban	60 minutes or 60 miles from the personal residence of members	100%+
Behavioral Health—Outpatient	30 minutes or 30 miles from the personal residence of members	100%+
General Optometry	30 minutes or 30 miles	99.9%+
Lab and X-ray Services	30 minutes or 30 miles	99.9%+
Pharmacies	30 minutes or 30 miles	100%+

ICF/ID = Intermediate Care Facilities for Individuals with Intellectual Disability
ICF/SNF = Intermediate Care Facilities/Skilled Nursing Facilities

Table 3-18—ITC Q2 Compliance With LTCS-HCBS Minimum Providers per County

Provider Type	Indicator	Compliance
Long-Term Care Services (LTCS)—HCBS [Home- and Community-Based Service] Providers	At least two providers per county for each covered HCBS in the benefit package for each 1915(c) waiver	*Met^*

^Indicates compliance based on an HHS approved exception.

HSAG assessed results submitted by **ITC** that indicated compliance with the minimum provider agreement requirements for all provider types. Compliance was determined based on the MCO meeting HHS' minimum provider agreement standard of at least one provider. Table 3-19 summarizes compliance with the minimum provider agreement indicators for **ITC**.

Table 3-19—ITC Minimum Provider Agreements by Provider Type

Provider Type	Compliance
Allergy	*Met*
Cardiology	*Met*
Dermatology	*Met*
Endocrinology	*Met*
Gastroenterology	*Met*
General Surgery	*Met*
Hematology	*Met*
Neonatology	*Met*
Nephrology	*Met*
Neurology	*Met*
Obstetrics and Gynecology	*Met*
Occupational Therapy	*Met*
Oncology	*Met*
Ophthalmology	*Met*
Orthopedics	*Met*

Provider Type	Compliance
Otolaryngology	*Met*
Pathology	*Met*
Physical Therapy	*Met*
Pulmonology	*Met*
Psychiatry	*Met*
Radiology	*Met*
Reconstructive Surgery	*Met*
Rheumatology	*Met*
Speech Therapy	*Met*
Urology	*Met*
Pediatric Specialties	*Met*

ITC did not have a completed appointment wait time survey report for the period in scope of review; therefore, appointment wait time indicators were not able to be validated for **ITC** as noted in Table 3-20.

Table 3-20—ITC Appointment Wait Time Indicators *Unable to Validate*

Provider Type	Indicator
PCP	Not to exceed four to six weeks from the date of a patient's request for a routine appointment, within 48 hours for persistent symptoms and urgent within one day.
Specialty Care	Not to exceed 30 days for routine care or one day for urgent care for non-dual enrolled members.
Behavioral Health Services—*Emergency*	Members with emergency needs shall be seen or referred to an appropriate provider upon presentation at a service delivery site.
Behavioral Health Services—*Mobile Crisis*	Members in need of mobile crisis services shall receive services within one hour of presentation or request.
Behavioral Health Services—*Urgent*	Members with urgent non-emergency needs shall be seen or referred to an appropriate provider within one hour of presentation at a service delivery site or within 24 hours of telephone contact with the provider or the Contractor.

Provider Type	Indicator
Behavioral Health Services—*Persistent Symptoms*	Members with persistent symptoms shall be seen or referred to an appropriate provider within 48 hours or reporting symptoms.
Behavioral Health Services—*Routine*	Members with the need for routine services shall be seen or referred to an appropriate provider within three weeks of the request for an appointment.
Behavioral Health Services—*Substance Use Disorder & Pregnancy*	Members who are pregnant women in need of routine substance use disorder services must be admitted within 48 hours of seeking treatment.
Behavioral Health Services—*Intravenous Drug Use*	Members who are intravenous drug users must be admitted not later than 14 days after making the request for admission, or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request.
Emergency Care	All emergency care is immediate, at the nearest facility available, regardless of whether the facility or provider is under contract with the Contractor.
General Optometry Services	Not to exceed three weeks for regular appointments and 48 hours for urgent care.
Lab and X-Ray Services	Not to exceed three weeks for regular appointments and 48 hours for urgent care.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: To ensure member access to providers where access may be particularly challenging, **ITC** placed a strong focus on expanding its provider network, including collaborating with providers in neighboring states, developing Single Case Agreements where feasible, focusing on rural parts of the state, and placing emphasis on outreach for LTCS providers. [**Quality** and **Access**]

Strength #2: ITC's addition of Veda to assist in provider data cleaning and validation resulted in noted improvement in accuracy of provider data as evidenced in feedback received by **ITC** during audits conducted by CMS. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: ITC submitted network adequacy reports that were named with the quarter and date the report was generated rather than the quarter the report was based on and the date the report was generated. [**Quality**]

Why the weakness exists: There was a lack of standardized naming conventions for network adequacy reports, which led to inconsistencies between the report names and the periods they represent.

Recommendation: HSAG recommends that **ITC** review network adequacy report naming conventions to reflect the period of time the report represents along with the generation date to ensure alignment with the GeoAccess reports posted on the HHS website.

Weakness #2: For several provider types, some time/distance indicators were considered "met" based on an approved exception from HHS due to factors such as a lack of available providers. [**Access**]

Why the weakness exists: Persistent provider shortages in certain specialties and geographic areas limited **ITC**'s ability to meet standard time/distance requirements without exceptions.

Recommendation: HSAG recommends that **ITC** continue to focus on solutions it has found to be effective in expanding its provider network, and consider collaborating with HHS and other MCOs in its employment of small tests of change via its use of Plan-Do-Study-Act (PDSA) processes, to target creative solutions to address provider network challenges.

Encounter Data Validation

Performance Results

ITC representatives procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to HHS.

Table 3-21 outlines the key findings for ITC based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from July 1, 2023, through June 30, 2024.

Table 3-21—EDV Summary of Key Findings: ITC

Analysis	Key Findings
Medical Record Review	
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate for ITC was high at 94.9 percent, indicating that most requested records were successfully procured and submitted. • All submitted records were deemed valid and reviewed by HSAG.
Second Date of Service Submission Rate	• Among the requested sampled records, 48.7 percent included a corresponding second date of service. Of these records, HSAG reviewed 96.5 percent.
Encounter Data Completeness	
Medical Record Omission Rate	• While the medical record omission rate for the *Procedure Code Modifier* data element was above 10.0 percent (at 10.5 percent), medical record omission rates for the remaining data elements were below 10.0 percent, ranging from 3.5 percent (*Date of Service*) to 8.3 percent (*Procedure Code*).
Encounter Data Omission Rate	• All encounter data omission rates were below 10.0 percent, ranging from 0.7 percent (*Diagnosis Code*) to 3.3 percent (*Procedure Code Modifier*).
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The accuracy rate for the *Diagnosis Code* data element was 99.2 percent. All errors were attributable to inaccurate coding.

Analysis	Key Findings
Procedure Code Accuracy Rate	• The accuracy rate for the *Procedure Code* data element was 98.7 percent. The most common error type was related to inaccurate coding (50.0 percent).
Procedure Code Modifier Accuracy Rate	• The accuracy rate for the *Procedure Code Modifier* data element was 100 percent.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in 82.5 percent of dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: A high proportion of the *Date of Service*, *Diagnosis Code*, and *Procedure Code* data elements reported in the encounter data were supported by the members' medical records, as evidenced by the medical record omission rates below 10.0 percent for these data elements. [**Quality**]

Strength #2: Key data elements documented in members' medical records were generally captured in the encounter data, as evidenced by the low encounter data omission rates across all evaluated data elements (i.e., 3.3 percent or below for *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data elements). [**Quality**]

Strength #3: When present in both the encounter data and members' medical records, and evaluated independently, the key data element values were found to be accurate with rates of at least 98.7 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The medical record omission rate for the *Procedure Code Modifier* data element was elevated at 10.5 percent, indicating that a notable proportion of procedure code modifiers reported in the encounter data were not supported by documentation in the members' medical records. [**Quality**]

Why the weakness exists: The elevated medical record omission rate for the Procedure Code Modifier data element was primarily attributable to documentation gaps, including instances in

which medical records did not contain sufficient evidence to support the reported modifiers, even though the associated procedure codes were present. In addition, cases in which medical records were not submitted or did not support the sampled date of service resulted in all associated procedure code modifiers being treated as medical record omissions, further contributing to the elevated rate.

Recommendation: ITC should strengthen its provider documentation practices related to procedure code modifiers by reinforcing expectations that medical records clearly document the clinical circumstances supporting the use of modifiers (e.g., modifier-specific requirements). **ITC** should consider conducting targeted reviews of claims with procedure code modifiers, providing focused education and feedback to providers on modifier documentation standards, and incorporating modifier-specific checks into existing auditing or quality assurance processes to reduce medical record omission rates in future reviews.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-22 presents ITC's 2025 adult Medicaid and general child Medicaid CAHPS top-box scores.[13] Arrows (↓ or ↑) indicate 2025 scores that were statistically significantly higher or lower than the 2024 national average.

Table 3-22—Summary of CY 2025 CAHPS Top-Box Scores for ITC

	2025 Adult Medicaid	2025 General Child Medicaid
Composite Measures		
Getting Needed Care	87.57% ↑	88.27% ↑
Getting Care Quickly	88.78% ↑	90.23% ↑
How Well Doctors Communicate	94.56%	96.38% ↑
Customer Service	93.19% ↑	89.95%
Global Ratings		
Rating of All Health Care	52.03%	67.85%
Rating of Personal Doctor	72.79%	80.54% ↑
Rating of Specialist Seen Most Often	60.75% ↓	73.33%
Rating of Health Plan	60.34%	71.83%
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	69.42%	—
Discussing Cessation Medications	50.91%	—
Discussing Cessation Strategies	46.21%	—

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

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

↑ Indicates the 2025 score is statistically significantly higher than the 2024 national average.

↓ Indicates the 2025 score is statistically significantly lower than the 2024 national average.

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

Strengths, Weaknesses, and Recommendations

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

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

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

Strengths

Strength #1: ITC's 2025 top-box scores were statistically significantly higher than the 2024 NCQA adult Medicaid national averages for the following measures: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. [**Quality**, **Timeliness**, and **Access**]

Strength #2: ITC's 2025 top-box scores were statistically significantly higher than the 2024 NCQA child Medicaid national averages for the following measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Personal Doctor*. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: ITC's 2025 top-box score was statistically significantly lower than the 2024 NCQA adult Medicaid national average for one measure, *Rating of Specialist Seen Most Often*. **[Quality]**

Why the weakness exists: When compared to national benchmarks, the results indicate that adult members did not rate the specialist they saw most often highly.

Recommendation: HSAG recommends that **ITC** collect regular feedback throughout the year to identify member input through town halls, focus groups, and short surveys. For example, members could be sent a short survey following an appointment with a specialist to ask about the timeliness and quality of care received. Additionally, **ITC** might research if any specialty types do not meet network adequacy standards, which would impact access to care. HSAG also recommends that **ITC** identify trends in the data that might contribute to the lower performance through stratifying by race/ethnicity, age, ZIP Code, and gender. Once a root cause or probable reasons for lower ratings are identified, **ITC** can determine appropriate interventions, education, and actions to improve performance.

Scorecard

The 2025 Iowa Managed Care Program MCO Scorecard was designed to compare MCO-to-MCO performance using HEDIS and CAHPS measure indicators. As such, MCO-specific results are not included in this section. Refer to the Scorecard activity in Section 7—MCP Comparative Information to review the 2025 Iowa Health Link MCO Scorecard, which is inclusive of **ITC**'s performance.

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

HSAG performed a comprehensive assessment of ITC's aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how ITC's overall performance contributed to the Iowa Managed Care Program's progress in achieving the Iowa HHS Medicaid Quality Strategy strategic priorities and objectives. Table 3-23 displays each strategic priority and the EQR activity results that indicate whether the MCO positively (✓), negatively (✗), or minimally (●) impacted the Iowa Managed Care Program's progress toward achieving the applicable strategic priorities and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to ITC's Medicaid and Hawki members. Additionally, not applicable (**NA**) was used if an Iowa HHS Medicaid Quality Strategy priority or related objective did not include any quality measures for ITC's programs or the EQR activities did not produce data to assess the impact under an Iowa HHS Medicaid Quality Strategy objective.

Table 3-23—Overall Performance Impact to Iowa HHS Medicaid Quality Strategy and Quality, Timeliness, and Access

Strategic Priority	Overall Performance Impact	Performance Domain
1.0 Access to Care	**Improve Behavioral Health Network Adequacy** ✓ ITC achieved rates at or above the 90th percentile for *Follow-Up After Hospitalization for Mental Illness* for both the 7-day and 30-day indicators. **Improve Access to Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to Primary Care and Specialty Care** NA In CY 2025, the *SDOH Screening* PIP was continued, and ITC received a designation of *High Confidence* for Validation Rating 1 of the Design phase. However, as only baseline data were reported for this PIP in CY 2025, progress toward achieving the Iowa HHS Medicaid Quality Strategy objective could not be assessed. As this PIP's interventions have the potential to impact this objective, progress will be assessed in future technical reports. NA The NAV EQR activity did not produce sufficient data to assess the impact of provider-to-member ratios for this objective. However, the Iowa HHS Medicaid Quality Strategy indicated that HHS would update the network adequacy standards to include minimum	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	required provider-to-member ratios for PCPs and specialists. As such, performance of these measures will be assessed in future technical reports when included as part of the NAV and compliance activities.	
2.0 Whole Person Coordinated Care	**Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis** ✓ **ITC**'s performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate for MY 2024 (83.36 percent) indicates it achieved the Iowa HHS Medicaid Quality Strategy objective to *Increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% by SFY2027.* ✓ **ITC**'s measure rate of 54.18 percent for *Initiation of SUD Treatment—Total* and 20.11 percent for *Engagement of SUD Treatment—Total* indicated it achieved the Iowa HHS Medicaid Quality Strategy objective to *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.* ✗ **ITC**'s performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure rate for MY 2024 (26.70 percent) decreased slightly from the MY 2023 rate (27.81 percent), indicating a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Increase Metabolic Monitoring for Children and Adolescents on Antipsychotics* (*Blood Glucose and Cholesterol*), *(APM) from 23.6% to 30% by SFY2027.* **Improve Prenatal and Postpartum Comprehensive Care Management** ✓ **ITC** demonstrated an increase over the past three years for the *Prenatal and Postpartum Care* measure rates, indicating it continues to positively impact the Iowa HHS Medicaid Quality Strategy objectives to *Increase prenatal visits in the first trimester by 5% (59%) by SFY2027 and increase Postpartum visits from 5% (32%) by SFY2027.*	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services NA *LTSS-6: LTSS Admission to a Facility from the Community*—While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS; therefore, ITC's impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports when data are available and as part of the PMV activity. NA *LTSS-7: LTSS Minimizing Facility Length of Stay*—While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS so ITC's impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity. NA *LTSS-8: LTSS Successful Transition After Long-Term Facility Stay*—While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS; therefore, ITC's impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity.	
3.0 Health Equity	**Address Disparities in Behavioral Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Primary and Specialty Care Services** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
4.0 Program Administration	**Grievances, Appeals, and Exception to Policy** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access
5.0 Voice of the Customer	✓ Through the 2025 CAHPS activity, **ITC** achieved a score that was statistically significantly higher than the 2024 national average in *Rating of Personal Doctor* for the general child Medicaid population, which aligned with the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. ✓ Through the 2025 CAHPS activity, **ITC** achieved a score that was statistically significantly higher than the 2024 national average for three of the general composite measures (*Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate)* for the general child Medicaid population, which aligned with the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. • **ITC**'s score for *Rating of All Health Care* for the general child Medicaid population was 67.85 percent, which was not statistically significantly higher or lower than the national average. Therefore, minimal impact was made on the objective to *Use the national average as a benchmark for CAHPS survey questions*. • **ITC** achieved a score of 46.21 percent for *Discussing Cessation Strategies* for the adult Medicaid population, which was not statistically significantly higher or lower than the national average. Therefore, minimal impact was made on the objective to *Use the national average as a benchmark for CAHPS survey questions*. • **ITC** achieved a score of 89.95 percent for the Customer Service composite measure for the child Medicaid population, which was not statistically significantly higher or lower than the national average. Therefore, minimal impact was made on the objective to *Use the national average as a benchmark for CAHPS survey questions*.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	✗ For the adult Medicaid population, **ITC** had a score for the *Rating of Specialist Seen Most Often* of 60.75 percent, which was statistically significantly lower than the 2024 national average, indicating a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*.	

Molina Healthcare of Iowa, Inc.

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **MOL**'s PIP (i.e., the PIP Design and Implementation stage). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-24 displays the validation ratings and performance indicators.

Table 3-24—Overall Validation Rating for MOL

PIP Topic	Validation Rating 1*	Validation Rating 2**	Performance Indicator	Performance Indicator Results		
				Baseline	R1	R2
Nonclinical PIP: *SDOH Screening*	*High Confidence*	*Not Assessed*	Newly enrolled Medicaid: The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.	81.4%	—	—
			Existing enrolled Medicaid: The percentage of existing members who received a subsequent screening for SDOH during the measurement period.	85.6%	—	—
Clinical PIP: *Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)*	*High Confidence*	*Not Assessed*	Initiation Phase: The percentage of the eligible population that had one follow-up visit during the 30-day initiation phase.	52.1%	—	—
			Continuation and Maintenance Phase: The percentage of the eligible population who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	48.7%	—	—

Validation Rating 1 = Overall confidence of adherence to acceptable methodology for all phases of the PIP.
Validation Rating 2 = Overall confidence that the PIP achieved significant improvement.
R1 = Remeasurement 1
R2 = Remeasurement 2
Gray shading with a dash (—) = The PIP had not progressed to reporting R1, or R2 results during SFY 2025.
* Based on the scores assigned for individual evaluation elements in the PIP Validation Tool and the confidence level definitions provided in Appendix A.
** Not Assessed—HSAG did not assess Validation Rating 2 for CY 2025 as the MCO reported the Design and Implementation stage for each PIP.

The goal for both PIPs is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Table 3-25 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MCO to support achievement of the PIP goals and address the barriers.

Table 3-25—Barriers and Interventions for MOL

SDOH Screening	
Barriers	**Interventions**
Member understanding, perceived benefit, and availability.	Community-based member SDOH screening and incentive.
Member contact information.	Updated member contact information for care manager.
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	
Barriers	**Interventions**
Scheduling limitations and provider understanding.	Provider incentive and education.
Member understanding.	Member outreach and education.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MOL created sound PIP designs and has the foundation to progress to subsequent PIP stages. [**Quality**]

Strength #1: MOL used appropriate quality improvement tools to identify barriers to care and developed interventions that can reasonably impact the performance indicators. [**Quality**]

Weaknesses and Recommendations

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

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends that **MOL** evaluate the effectiveness of each intervention effort to determine its impact and guide decisions on next steps.

Performance Measure Validation

Performance Results

PMV

HSAG reviewed **MOL**'s eligibility and enrollment data system, claims and encounter data processing system, provider data system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, **MOL** demonstrated it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report accurate encounter data and performance measure rates to HHS. During the interview component of the review, the member-level data used by **MOL** to calculate the performance measure rates were readily available for the auditor's review. However, during the audit HSAG identified misalignments between **MOL**'s source code and the technical specifications. **MOL** corrected its source code during the audit and submitted updated member-level detail files for specification alignment. Table 3-26 displays the indicator rates for each performance measure reported by **MOL**.

Table 3-26—MOL MY 2024 MLTSS Performance Measures

	LTSS Performance Measures	Denominator	Numerator	Performance Measure Rate
Medicaid MLTSS Admission to a Facility from the Community (MLTSS-6)				
1.	*Short-Term Stay—18–64 Years*	8,612	814	94.52
	Short-Term Stay—65–74 Years	371	184	495.96
	Short-Term Stay—75–84 Years	352	157	NA
	Short-Term Stay—85+ Years	192	15	NA
	Medium-Term Stay—18–64 Years	8,612	199	23.11
	Medium-Term Stay—65–74 Years	371	35	94.34
	Medium-Term Stay—75–84 Years	352	20	NA
	Medium-Term Stay—85+ Years	192	9	NA
	Long-Term Stay—18–64 Years	8,612	149	17.30
	Long-Term Stay—65–74 Years	371	12	32.35
	Long-Term Stay—75–84 Years	352	17	NA
	Long-Term Stay—85+ Years	192	10	NA
Medicaid MLTSS Minimizing Facility Length of Stay (MLTSS-7)				
2.	*Observed Rate*	1,113	147	13.21%
	Risk-Adjusted Rate	1,113	272.4872	24.48%
	O/E Ratio	272.4872	147	0.5395

LTSS Performance Measures		Denominator	Numerator	Performance Measure Rate
Medicaid MLTSS Successful Transition After Long-Term Facility Stay (MLTSS-8)				
3.	*Observed Rate*	174	9	5.17%
	Risk-Adjusted Rate	174	81.0693	46.59%
	O/E Ratio	81.0693	9	0.1110

"NA" indicates that the denominator was too small to report a valid rate.

HEDIS

HSAG's review of the Final Audit Report (FAR) for HEDIS MY 2024 showed that **MOL**'s HEDIS compliance auditor found **MOL**'s information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. **MOL** contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. **MOL** was a new MCO in Iowa effective July 1, 2023; therefore, the MCO does not have data to display for prior year rates. Table 3-27 displays the indicator rates for each HEDIS MY 2024 performance measure reported by **MOL**.

Table 3-27—HEDIS MY 2024 Results for MOL

Measures	HEDIS MY 2024 Rate	Star Rating
Access to Preventive Care		
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	77.24%	★★★
45–64 Years	81.13%	★★
65+ Years	85.45%	★★★
Use of Imaging Studies for Low Back Pain		
Total	64.83%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI percentile—Total	66.42%	★
Counseling for Nutrition—Total	55.72%	★
Counseling for Physical Activity—Total	51.09%	★
Women's Health		
Breast Cancer Screening		
Breast Cancer Screening	NA	NC
Cervical Cancer Screening		
Cervical Cancer Screening	45.04%	★
Chlamydia Screening in Women		
Total	45.71%	★

Measures	HEDIS MY 2024 Rate	Star Rating
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	80.54%	★
Postpartum Care	80.54%	★★
Living With Illness		
Glycemic Status Assessment for Patients With Diabetes		
Glycemic Status <8.0%	54.01%	★
*Glycemic Status >9.0%**	36.74%	★
Blood Pressure Control for Patients With Diabetes		
Blood Pressure Control for Patients With Diabetes	72.75%	★★★
Eye Exam for Patients With Diabetes		
Eye Exam for Patients With Diabetes	51.82%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	63.50%	★
Statin Therapy for Patients With Cardiovascular Disease		
Received Statin Therapy—Total	NA	NC
Statin Therapy for Patients With Diabetes		
Received Statin Therapy	NA	NC
Behavioral Health		
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	64.19%	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.76%	★
Follow-Up After Emergency Department Visit for Substance Use		
7-Day Follow-Up—Total	39.71%	★★★★★
30-Day Follow-Up—Total	53.91%	★★★★★
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	57.10%	★★★★
30-Day Follow-Up—Total	70.32%	★★★★
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	40.19%	★★★
30-Day Follow-Up—Total	62.08%	★★★
Initiation and Engagement of Substance Use Disorder Treatment		
Initiation of SUD Treatment—Total	53.97%	★★★★
Engagement of SUD Treatment—Total	17.68%	★★★

Measures	HEDIS MY 2024 Rate	Star Rating
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Blood Glucose and Cholesterol Testing—Total	25.53%	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
Total	60.24%	★★
Keeping Kids Healthy		
Childhood Immunization Status		
Combination 3	68.59%	★★★
Combination 10	30.37%	★★★
Immunizations for Adolescents		
Combination 1	82.00%	★★★
Combination 2	33.58%	★★
Lead Screening in Children		
Lead Screening in Children	80.78%	★★★★
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	66.17%	★★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	74.08%	★★★
Child and Adolescent Well-Care Visits		
Total	56.52%	★★★
Medication Management		
Statin Therapy for Patients With Cardiovascular Disease		
Statin Adherence 80%—Total	NA	NC
Statin Therapy for Patients With Diabetes		
Statin Adherence 80%	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	61.74%	★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	55.90%	★
Effective Continuation Phase Treatment	39.72%	★
Appropriate Testing for Pharyngitis		
Total	88.44%	★★★
Asthma Medication Ratio		
Total	NA	NC
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis		
Total	55.47%	★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	52.11%	★★★★

Measures	HEDIS MY 2024 Rate	Star Rating
Continuation and Maintenance Phase	48.70%	★
Appropriate Treatment for Upper Respiratory Infection		
Total	88.93%	★★★
Persistence of Beta-Blocker Treatment After a Heart Attack		
Persistence of Beta-Blocker Treatment After a Heart Attack	48.15%	★
Pharmacotherapy Management of COPD Exacerbation		
Bronchodilator	80.07%	★★
Systemic Corticosteroid	75.95%	★★★
Use of Opioids at High Dosage*		
Use of Opioids at High Dosage	1.04%	★★★★
Use of Opioids From Multiple Providers*		
Multiple Pharmacies	2.29%	★★★
Multiple Prescribers	19.54%	★★
Multiple Prescribers and Multiple Pharmacies	1.74%	★★

* For this indicator, a lower rate indicates better performance.
"NA" indicates that the denominator was too small to calculate a rate (n<30); therefore, a rate is not displayed.
"NC" indicates Not Compared, rates with small denominators are not compared to benchmarks.
HEDIS MY 2024 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★ = At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★= At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: For the Behavioral Health domain, **MOL**'s measure indicator rates for *Follow-Up After Emergency Department Visit for Substance Use, Follow-Up After Emergency Department Visit for Mental Illness,* and *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total* finished at or above the 75th percentile. [**Quality**, **Timeliness**, and **Access**]

Strength #2: For the Keeping Kids Health domain, **MOL**'s measure indicator rate for *Lead Screening in Children* finished at or above the 75th percentile. [**Quality** and **Access**]

Strength #3: For the Medication Management domain, **MOL**'s measure indicator rates for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Use of Opioids at High Dosage* finished at or above the 75th percentile. [**Quality** and **Access**]

Strength #4: MOL demonstrated multiple methods of validation and tracking to ensure the accuracy and completeness of its enrollment data, claims adjudication, and encounter data. [**Quality**]

Strength #5: MOL used an NCQA-certified product containing built-in cleansing and validation rules to conduct member matches and identify data anomalies when calculating its performance measure rates. ClaimSphere[14] followed the NCQA guidelines for development and testing of all performance measure source code to help improve the accuracy of **MOL**'s performance measure rate calculations. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Within the Women's Health domain, **MOL**'s measure indicator rates for *Cervical Cancer Screening, Chlamydia Screening in Women,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* finished below the 25th percentile. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Low chlamydia screening rates suggest that barriers exist for sexually active women 16 to 24 years of age to access this important health screening or potentially may stem from missed opportunities during in-office visits, such as those for pregnancy testing, contraception services, and annual exams. HSAG suggests several key drivers that contribute to low performance in *Timeliness of Prenatal Care* rates. These key drivers include, but are not limited to, access to timely care and services, transportation barriers, and education and cultural beliefs. Barriers to timely access to care and services can result in increased non-urgent ED utilization and increased healthcare costs.

Recommendation: HSAG recommends that **MOL** research interventions, including provider outreach and education, member education and outreach, and tracking of chlamydia screening rates and reporting those results to physicians and large practices. HSAG also recommends that **MOL** research promoting telemedicine and home monitoring to increase access to prenatal care.[15]

Weakness #2: Within the Behavioral Health domain, **MOL**'s measure indicator rates for *Diabetes Monitoring for People With Diabetes and Schizophrenia, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications,* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics* all finished below the 25th percentile. [**Quality**, **Timeliness**, and **Access**]

[14] ClaimSphere® is a registered trademark owned by Cognizant Technology Solutions U.S. Corporation.
[15] American College of Obstetricians & Gynecologists. *Tailored Prenatal Care Delivery for Pregnant Individuals.* Washington, DC: ACOG; 2025: Number 8.

Why the weakness exists: The low rate indicates there are barriers to appropriate monitoring for members with severe and persistent mental illness who are being treated with psychotropic medication, potentially with behavioral health providers not ordering the correct tests for monitoring.

Recommendation: HSAG recommends that **MOL** assess how providers are coordinating on antipsychotic care and encourage joint PCP/mental health provider monitoring to potentially increase the rate of metabolic monitoring. Further, HSAG recommends that **MOL** evaluate if any potential enhancements can be made to provider data reports to clearly identify trends in whether providers are prescribing antipsychotics without metabolic monitoring.

Weakness #3: Within the Medication Management domain, **MOL**'s measure indicator rates for *Antidepressant Medication Management, Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase,* and *Persistence of Beta-Blocker Treatment After a Heart Attack* finished below the 25th percentile. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Low rates indicate there are barriers to appropriate monitoring for members who are being treated with antidepressants, ADHD medications, and beta-blockers.

Recommendation: HSAG recommends that **MOL** consider an analysis of key drivers using a segmentation analysis in which noncompliant members of each measure are stratified by age, gender, race, geography, and provider. Results of this type of analysis can help to identify key drivers that could be focal points for member-focused or provider-focused interventions that would be effective with a large proportion of the noncompliant population.

Weakness #4: **MOL** confirmed that multiple facility stays were not included in its measure calculations, as the billed UB codes did not align with the required MLTSS measures value sets. **MOL** confirmed that the billed UB codes aligned with HHS' billable codes, per HHS' *Informational Letter 2601-MC-FFS Revenue Code Billing for Managed Care Organization (MCO) Claims* and UB claim form instructions. [**Quality**]

Why the weakness exists: **MOL** has not explored the potential use of codes not included in the measure value set by mapping to allowable value set codes.

Recommendation: HSAG suggests that **MOL** consult with HHS to understand whether any of the billable codes not included in the MLTSS measures value set can be accurately mapped to the allowable value set codes for future audits. HSAG also recommends that **MOL** work in conjunction with its contracted facilities to provide insight regarding codes within the MLTSS measures value set and to ensure billed codes accurately represent the code subcategory for facility stays of each member.

Compliance Review

Performance Results

Table 3-28 presents an overview of the results of the standards reviewed during the CY 2025 compliance review for **MOL**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **MOL** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-28—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	20	20	19	1	0	**95%**
Standard IX—Confidentiality	21	21	21	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	6	6	6	0	0	**100%**
Standard XIII—Health Information Systems	9	9	9	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	19	19	19	0	0	**100%**
Total	**120**	**120**	**112**	**8**	**0**	**93%**

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MOL achieved full compliance for the Confidentiality program area, demonstrating that the MCO had adequate processes in place to ensure compliance with the requirements stipulated in 45 CFR parts 160 and 164, subparts A and E. [**Quality**]

Strength #2: MOL achieved full compliance for the Subcontractual Relationships and Delegation program area, demonstrating that the MCO had policies and processes in place to provide sufficient oversight and monitoring of its delegated entities (e.g., delegated responsibilities, reporting requirements, and compliance with federal and State requirements). [**Quality**]

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

Strength #4: MOL achieved full compliance for the Health Information Systems program area, demonstrating that the MCO had systems in place to maintain a health information system that collects, analyzes, integrates, and provides members access to their data. [**Quality**, **Timeliness**, and **Access**]

Strength #5: MOL achieved full compliance for the Quality Assessment and Performance Improvement Program area, demonstrating that the MCO had adequate procedures and processes in place to support the provision of quality services to its members, maintain sufficient quality monitoring activities to assess ongoing performance, and conduct timely implementation of strategies to mitigate identified opportunities for improvement. [**Quality**]

Weaknesses and Recommendations

Weakness #1: MOL had six elements in the Grievances and Appeals program area that received a score of *Not Met*, indicating that the MCO had not implemented a member grievance and appeal process in accordance with all federal and/or contractual requirements. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Through a review of written policies and procedures and case files, gaps in **MOL**'s processes were identified related to fully resolving grievances prior to closing the case; obtaining written consent from members for an individual to file appeals on their behalf; and providing members with timely oral and written appeal resolution notices, an oral notice of the denial of an expedited resolution of an appeal, and timely reinstatement of services.

Recommendation: While **MOL** was required to develop a CAP to address the identified deficiencies, HSAG recommends that the MCO enhance oversight and monitoring of its grievance and appeal processes by conducting a comprehensive review of a random sample of grievance and appeal files and implement corrective action for all identified deficiencies.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data were accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MCO according to the CMS EQR Protocol 4 and as defined in Table A-11 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 3-29 presents a summary of the NAV validation ratings for **MOL** by network adequacy standard type.

Table 3-29—Summary of MOL Validation Ratings by Standard Type

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias	Could Not Be Validated
Time/Distance	100%	0%	0%	0%	0%
Minimum Provider Agreements	100%	0%	0%	0%	0%
Appointment Wait Time	100%	0%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 53 indicators for **MOL**. All 15 Time/Distance indicators received a rating of *High Confidence,* all 26 Minimum Provider Agreements received a rating of *High Confidence,* and the remaining 12 Appointment Wait Time indicators received a rating of *High Confidence.*

HSAG assessed results submitted by **MOL** that included data reported as of December 31, 2024, representing a snapshot in time and summarizing cumulative network adequacy data collected over the preceding 12 months, and that indicated compliance with the network adequacy time and distance standards. Table 3-30 summarizes the percentage of members with access to the time and distance network adequacy indicators for the most recent available results during the reporting period. The compliance threshold for Primary Care Providers (PCP), General Optometry, Lab and X-ray Services, and Pharmacies is 100 percent. The compliance threshold for Specialty Care Providers is access for at least 75 percent of members within 60 minutes or 60 miles and access for at least 99.5 percent of members within 90 minutes or 90 miles. Results that achieved the required percent threshold are shaded green and marked with a plus sign.

Table 3-30—MOL Q2 Percentage of Members With Access Across Time and Distance Indicators

Provider Type	Indicator	Percentage of Members With Access
PCP—Adult	30 minutes or 30 miles from the personal residences of members	99.7%+
PCP—Pediatric	30 minutes or 30 miles from the personal residences of members	99.8%+
Allergy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Allergy—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	89.3%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Cardiology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Cardiology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Dermatology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+

Provider Type	Indicator	Percentage of Members With Access
Dermatology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	64.5%
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	82.6%
Endocrinology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Endocrinology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Gastroenterology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Gastroenterology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
General Surgery—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+

Provider Type	Indicator	Percentage of Members With Access
General Surgery—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Hematology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Hematology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.3%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Long-Term Care Services—*Institutional Providers:* ICF/ID—Individuals with Intellectual Disabilities—Urban	30 minutes or 30 miles	100%+
Long-Term Care Services—Institutional Providers: ICF/ID—Individuals with Intellectual Disabilities—Rural	60 minutes or 60 miles	99.9%+
Long-Term Care Services—*Institutional Providers:* ICF/SNF—Skilled Nursing Care Facility—Urban	30 minutes or 30 miles	100%+
Long-Term Care Services—*Institutional Providers:* ICF/SNF—Skilled Nursing Care Facility—Rural	60 minutes or 60 miles	99.9%+

Provider Type	Indicator	Percentage of Members With Access
Neonatology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.6%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.6%+
Nephrology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Nephrology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Neurology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.9%+
Neurology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Neurosurgery—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.7%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+

Provider Type	Indicator	Percentage of Members With Access
OB/GYN—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Occupational Therapy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Oncology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Oncology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.3%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Ophthalmology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Ophthalmology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	0.0%
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	0.0%

Provider Type	Indicator	Percentage of Members With Access
Orthopedics—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Orthopedics—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	83.5%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	91.5%
Otolaryngology (ENT)—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Otolaryngology (ENT)—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	85.2%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	91.7%
Pathology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Physical Therapy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+

Provider Type	Indicator	Percentage of Members With Access
Psychiatry—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Pulmonology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Pulmonology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Radiology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Reconstructive Surgery—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.7%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Rheumatology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+

Provider Type	Indicator	Percentage of Members With Access
Rheumatology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	95.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Speech Therapy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.7%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Urology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.8%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Urology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.7%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	99.8%+
Hospital	30 minutes or 30 miles	99.7%+
Behavioral Health—Inpatient—Rural	90 minutes or 90 miles from the personal residence of members	99.9%+
Behavioral Health—Inpatient—Urban	60 minutes or 60 miles from the personal residence of members	100%+
Behavioral Health—Outpatient	30 minutes or 30 miles from the personal residence of members	99.7%+
General Optometry	30 minutes or 30 miles	99.7%+
Lab and X-ray Services	30 minutes or 30 miles	99.8%+
Pharmacies	30 minutes or 30 miles	99.7%+

Table 3-31—MOL Q2 Compliance With LTCS-HCBS Minimum Providers per County

Provider Type	Indicator	Compliance
Long-Term Care Services—HCBS [Home- and Community-Based Service] Providers	At least two providers per county for each covered HCBS in the benefit package for each 1915(c) waiver	*Not Met* Although **MOL** had approved exceptions for some LTCS-HCBS provider types that resulted in a *Met* status for those provider types, **MOL** did not have a minimum of two providers per county or HHS-approved exceptions for the LTCS-HCBS provider type subsets of Consumer-Directed Attendant Care (CDAC): HIV/AIDS, Elderly, HD, or ID, that resulted in a *Not Met* status for the entire indicator.

HSAG assessed results submitted by **MOL** that indicated compliance with the minimum provider agreement requirements for all provider types. Compliance was determined based on the MCO meeting HHS' minimum provider agreement standard of at least one provider. Table 3-32 summarizes compliance with the minimum provider agreement indicators for **MOL**.

Table 3-32—MOL Compliance With Minimum Provider Agreements by Provider Type

Provider Type	Compliance
Allergy	*Met*
Cardiology	*Met*
Dermatology	*Met*
Endocrinology	*Met*
Gastroenterology	*Met*
General Surgery	*Met*
Hematology	*Met*
Neonatology	*Met*
Nephrology	*Met*
Neurology	*Met*

Provider Type	Compliance
Obstetrics and Gynecology	*Met*
Occupational Therapy	*Met*
Oncology	*Met*
Ophthalmology	*Met*
Orthopedics	*Met*
Otolaryngology	*Met*
Pathology	*Met*
Physical Therapy	*Met*
Pulmonology	*Met*
Psychiatry	*Met*
Radiology	*Met*
Reconstructive Surgery	*Met*
Rheumatology	*Met*
Speech Therapy	*Met*
Urology	*Met*
Pediatric Specialties	*Met*

Table 3-33 summarizes **MOL**'s appointment wait time survey results of provider compliance with HHS-defined appointment wait time indicators.

Table 3-33—MOL Provider Network Percent Compliance For Appointment Wait Time Indicators

Provider Type	Indicator	Percent Within Standard
PCP	4 to 6 weeks for routine care	97%
	48 hours for persistent care	91%
	1 day for urgent care	94%
Specialty Care	30 days for routine care	100%
	1 day for urgent care	100%

Provider Type	Indicator	Percent Within Standard
Behavioral Health Services—*Emergency*	Members with emergency needs shall be seen or referred to an appropriate provider upon presentation at a service delivery site	52%
Behavioral Health Services—*Mobile Crisis*	Members in need of mobile crisis services shall receive services within one hour of presentation or request	100%
Behavioral Health Services—*Urgent*	1 hour of presentation or within 24 hours of telephone contact	86%
Behavioral Health Services—*Persistent Symptoms*	Seen or referred to appropriate provider within 48 hours	100%
Behavioral Health Services—*Routine*	Seen or referred to an appropriate provider within 3 weeks	100%
Behavioral Health Services—*Substance Use Disorder & Pregnancy*	Members who are pregnant women in need of routine substance use disorder services must be admitted within 48 hours of seeking treatment	86%
Behavioral Health Services—*Intravenous Drug Use*	Members who are intravenous drug users must be admitted not later than 14 days after making the request for admission, or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request	95%
Emergency Care	All emergency care is immediate, at the nearest facility available, regardless of whether the facility or provider is under contract with the Contractor	52%
General Optometry Services	Not to exceed three weeks for regular appointments and 48 hours for urgent care	100%
Lab and X-Ray Services	3 weeks regular appointments 48 hours urgent care	100%

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MOL established robust processes for inputting and maintaining provider data, including the use of third party vendors, HiLabs and ProviderTrust, to validate provider data on a monthly basis. [**Quality**]

Strength #2: MOL maintained an effective delegated oversight process, including an extensive annual audit of delegated entities, to ensure entities remain compliant with requirements and performance expectations. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Time and distance indicators for the provider types of Pediatric Otolaryngology, Orthopedics, and Dermatology, as well as several LTCS providers had approved exceptions from HHS due to factors such as a lack of available providers. **MOL** reported no access for Pediatric Ophthalmologists and had no approved exception reported from HHS. Additionally, for some LTCS provider types, **MOL** did not have approved exceptions, resulting in a *Not Met* status for LTCS providers overall. **MOL** indicated that for the provider types that did not meet access thresholds, it had adult providers that filled those gaps. [**Access**]

Why the weakness exists: As reported by **MOL**, persistent provider shortages in certain specialties and geographic areas limited **MOL**'s ability to meet standard time/distance requirements.

Recommendation: HSAG recommends that **MOL** continue to focus on solutions it has found to be effective in maintaining and expanding its provider network, including the identification of adult providers that may fill gaps for pediatric services, working with HHS to identify potential pediatric-specific providers to outreach, and monitoring of the state waiver service file to identify LTCS providers and notifications by HHS regarding new providers joining the Medicaid program.

Encounter Data Validation

Performance Results

Representatives from **MOL** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and encounter data submitted to HHS.

Table 3-34 outlines the key findings for **MOL** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from July 1, 2023, through June 30, 2024.

Additionally, for **MOL**, HSAG conducted a series of comparative analyses divided into three analytic sections: Record Completeness, Data Element Completeness and Accuracy, and Overall Encounter Accuracy. Table 3-34 also summarizes the key findings for **MOL** based on the evaluation of whether encounters submitted by **MOL** and maintained in HHS' data warehouse—subsequently extracted and submitted by HHS to HSAG for the study—are accurate and complete when compared to the data submitted to HSAG by **MOL**. The analysis targeted professional, institutional, and pharmacy encounters with dates of service from November 1, 2023, through October 31, 2024, with final[16] adjudication status on or before March 31, 2025, and submitted to HHS on or before April 30, 2025.

Table 3-34—EDV Summary of Key Findings: MOL

Analysis	Key Findings
Medical Record Review	
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate for **MOL** was low at 85.9 percent, indicating that more than 14 percent of requested records were not procured and submitted. • All submitted records were deemed valid and reviewed by HSAG.
Second Date of Service Submission Rate	• Among the requested sampled records, 25.1 percent included a corresponding second date of service. Of these records, HSAG reviewed 83.5 percent.
Encounter Data Completeness	
Medical Record Omission Rate	• All key data elements (i.e., *Date of Service, Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*) had

[16] For this study the term "final" refers to the most recent paid or denied iteration of the encounter on or before the cut-off date of March 31, 2025.

Analysis	Key Findings
	relatively high medical record omission rates above 10.0 percent, ranging from 11.8 percent (*Date of Service*) to 25.3 percent (*Procedure Code Modifier*).
Encounter Data Omission Rate	• All encounter data omission rates were below 10.0 percent, ranging from 0.9 percent (*Diagnosis Code*) to 2.9 percent (*Procedure Code*).
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The accuracy rate for the *Diagnosis Code* data element was 99.0 percent. The most common error type was related to inaccurate coding (63.6 percent).
Procedure Code Accuracy Rate	• The accuracy rate for the *Procedure Code* data element was 98.8 percent. The most common error type was related to inaccurate coding (81.8 percent).
Procedure Code Modifier Accuracy Rate	• The accuracy rate for the *Procedure Code Modifier* data element was 99.5 percent.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in 81.5 percent of dates of service present in both data sources (i.e., encounter data and medical records).
Comparative Analysis	
Record Omission and Record Surplus	• For professional encounters, both the record omission and record surplus rates were low at 1.0 percent and 0.4 percent, respectively. • For institutional encounters, both the record omission and record surplus rates were low at 0.9 percent and 1.0 percent, respectively. • For pharmacy encounters, the record omission rate was low at less than 1.0 percent; however, the record surplus rate was elevated at 5.7 percent.
Data Element Completeness	• For professional encounters, the data element omission rates were low across all evaluated key data elements, with the highest omission rate at 0.1 percent. Similarly, the data element surplus rates were also low, with all surplus rates at or below 2.0 percent. • For institutional encounters, the data element omission rates were low across all evaluated key data elements, with the highest omission rate at 3.8 percent. The data element surplus rates were similarly low, with the highest surplus rate below 0.1 percent.

Analysis	Key Findings
	• For pharmacy encounters, both element omission and element surplus rates were low, with the highest rate below 0.1 percent. • Overall, the consistently low data element omission and surplus rates across all three encounter types indicate a high level of element-level completeness between the HHS- and **MOL**-submitted files.
Data Element Accuracy	• For professional encounters, all key data elements exhibited high element accuracy rates of 96.8 percent or higher. • For institutional encounters, most key data elements exhibited high element accuracy rates; however, the *Secondary Diagnosis Code(s)* data element had a lower accuracy rate of 71.6 percent. • For pharmacy encounters, all evaluated data elements exhibited high accuracy, with each achieving an accuracy rate of 99.5 percent or greater.
All-Element Accuracy	• The all-element accuracy rates for professional and pharmacy encounters were 95.0 and 99.3 percent, respectively. • Institutional encounters exhibited a lower all-element accuracy rate of 72.8 percent, which was primarily attributable to lower accuracy for the *Secondary Diagnosis Code(s)* data element.
Overall Encounter Accuracy	• When comparing the HHS-submitted encounters to the **MOL**-submitted encounters, and vice versa, the professional encounter match rates were at 95.5 percent (HHS to **MOL**) and 95.5 percent (**MOL** to HHS). • Institutional encounter match rates were approximately 82 percent in both directions, with partial match rates of approximately 17 percent. The elevated partial match rates were consistent with the lower element accuracy rate observed for the *Secondary Diagnosis Code(s)* data element, which likely contributed to claim line and/or key data element differences between the two files. • For pharmacy encounters, the no match rate was higher, at 5.7 percent when comparing the HHS-submitted encounters to the **MOL**-submitted encounters. This result was consistent with the elevated pharmacy record surplus, reflecting pharmacy claims present in the HHS-submitted data that were not included in **MOL**'s pharmacy extract (e.g., denied claim encounters when a subsequent final paid claim was included instead).

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Key data elements documented in members' medical records were generally captured in the encounter data, as evidenced by the low encounter data omission rates across all evaluated data elements (i.e., 2.9 percent or below for the *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data elements). [**Quality**]

Strength #2: When present in both the encounter data and members' medical records and evaluated independently, the key data element values were found to be accurate with rates of at least 98.8 percent each. [**Quality**]

Strength #3: MOL demonstrated strong record-level completeness for professional and institutional encounters, as evidenced by the low record omission rates (1.0 percent and 0.9 percent, respectively) and the low record surplus rates (0.4 percent and 1.0 percent, respectively), indicating that most encounters were consistently represented between the **MOL**- and HHS-submitted files. [**Quality**]

Strength #4: Across all encounter types, key data elements exhibited low element-level omission and surplus rates, reflecting a high level of element-level completeness and consistent population of required data elements between **MOL**'s submissions and HHS' encounter data. [**Quality**]

Strength #5: When key data elements were present in both the **MOL**- and HHS-submitted files, data element accuracy rates were high. All professional encounter key data elements had accuracy rates of 96.8 percent or greater, all pharmacy encounter data elements achieved accuracy rates of 99.5 percent or greater, and 17 of 18 institutional data elements demonstrated accuracy rates of 99.4 percent or greater. [**Quality**]

Weaknesses and Recommendations

Weakness #1: MOL exhibited a low medical record procurement rate, which limited the availability of documentation to validate encounter data for sampled dates of service. [**Quality**]

Why the weakness exists: The lower procurement rate was largely driven by provider non-responsiveness or delayed responses to medical record requests. In some instances, providers did not submit records within the required timeframe or submitted incomplete documentation, reducing the proportion of records available for review.

Recommendation: MOL should strengthen its medical record procurement processes by reinforcing provider accountability for timely and complete medical record submission. This may include enhancing contractual requirements, implementing escalation procedures for non-responsive

providers, and conducting targeted outreach to providers with repeated noncompliance. Improving procurement rates would increase the completeness of documentation available for validation and reduce medical record omission rates in future reviews.

Weakness #2: MOL exhibited high medical record omission rates across all evaluated data elements (i.e., Date of Service, Diagnosis Code, Procedure Code, and Procedure Code Modifier), indicating that encounter data values were not consistently supported by medical record documentation. [**Quality**]

Why the weakness exists: The elevated medical record omission rates were largely attributable to the low medical record procurement rate, as medical record non-submission resulted in all associated data elements being treated as medical record omissions. Additional contributing factors included cases in which submitted medical records did not support the sampled date of service or lacked sufficient documentation to substantiate the reported services or modifiers.

Recommendation: MOL should investigate the root causes of medical record omissions and implement targeted corrective actions, including conducting periodic internal MRRs to assess documentation completeness, strengthening provider education related to documentation standards, and incorporating documentation checks into existing quality assurance processes. Addressing both procurement and documentation gaps would help reduce medical record omission rates across all data elements in future reviews.

Weakness #3: For pharmacy encounters, the record surplus rate exceeded the 5.0 percent threshold. [**Quality**]

Why the weakness exists: The elevated pharmacy surplus was primarily attributable to **MOL** excluding denied pharmacy claim encounters from its extract when a subsequent final paid claim for the same service was included. Because denied claims are not referenced or replaced in later transactions, these encounters appeared as surplus records in the comparative analysis when HHS served as the primary file.

Recommendation: MOL should work collaboratively with HHS to clarify and document pharmacy encounter resubmission and adjudication guidelines, particularly for denied and subsequently paid claims. Clear guidance will help reduce apparent surplus records while ensuring that final adjudication outcomes are accurately represented in encounter data submissions.

Weakness #4: For institutional encounters, the element accuracy rate fell below the 95.0 percent threshold for the *Secondary Diagnosis Code(s)* data element. [**Quality**]

Why the weakness exists: The lower accuracy was attributable to differences in how diagnosis-related fields were populated, as **MOL** included multiple diagnosis code types from the claim (e.g., primary and secondary diagnosis codes, primary reason for visit codes, trauma codes, and admit codes), which did not consistently align with HHS' formatting and placement of these values. These differences contributed to element-level discrepancies and higher partial match rates.

Recommendation: HSAG recommends that **MOL** collaborate with HHS to review and refine data extraction and reporting logic for the *Secondary Diagnosis Code(s)* data element. This effort should include enhanced validation checks, updated extraction documentation, and targeted training for staff involved in data preparation to ensure consistent interpretation and reporting of diagnosis-related fields.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-35 presents **MOL**'s 2025 adult Medicaid, general child Medicaid, and CCC Medicaid CAHPS top-box scores. Arrows (↓ or ↑) indicate 2025 scores that were statistically significantly higher or lower than the 2024 national average.

Table 3-35—Summary of CY 2025 CAHPS Top-Box Scores for MOL

	2025 Adult Medicaid	2025 General Child Medicaid	2025 CCC Medicaid Supplemental
Composite Measures			
Getting Needed Care	83.96%	87.06%	82.43%
Getting Care Quickly	81.60%	92.08% ↑	92.55% ↑
How Well Doctors Communicate	94.20%	94.99%	94.51%
Customer Service	NA	NA	NA
Global Ratings			
Rating of All Health Care	53.16%	72.60%	62.16%
Rating of Personal Doctor	68.25%	80.33%	80.32%
Rating of Specialist Seen Most Often	67.54%	NA	NA
Rating of Health Plan	54.75% ↓	64.90% ↓	59.20% ↓
Medical Assistance With Smoking and Tobacco Use Cessation Items*			
Advising Smokers and Tobacco Users to Quit	NA	—	—
Discussing Cessation Medications	NA	—	—
Discussing Cessation Strategies	NA	—	—
CCC Composite Measures/Items			
Access to Specialized Services	—	—	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	—	90.69%
Coordination of Care for Children With Chronic Conditions	—	—	NA
Access to Prescription Medicines	—	—	92.41%
FCC: Getting Needed Information	—	—	95.92% ↑

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

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

↑ Indicates the 2025 score is statistically significantly higher than the 2024 national average.

↓ Indicates the 2025 score is statistically significantly lower than the 2024 national average.

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MOL's 2025 top-box score was statistically significantly higher than the 2024 NCQA child Medicaid national average for one measure, *Getting Care Quickly*. [**Quality** and **Timeliness**]

Strength #2: MOL's 2025 top-box scores were statistically significantly higher than the 2024 NCQA CCC Medicaid national averages for the following measures: *Getting Care Quickly* and *FCC: Getting Needed Information*. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: MOL's 2025 top-box scores were statistically significantly lower than the 2024 NCQA adult Medicaid, general child Medicaid, and CCC Medicaid national average for one measure, *Rating of Health Plan*. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate that adult, child, and CCC members did not rate their health plan highly.

Recommendation: HSAG recommends that **MOL** conduct a key driver analysis to determine if specific aspects of care are driving lower levels of experience with the member's health plan. This could include analyzing visit appointment records to assess missed appointments, telephone logs, and complaint records. Additionally, **MOL** might research if access to primary care does not meet network adequacy standards, which would impact access to care.

Scorecard

The 2025 Iowa Managed Care Program MCO Scorecard was designed to compare MCO-to-MCO performance using HEDIS and CAHPS measure indicators. As such, MCO-specific results are not included in this section. Refer to the Scorecard activity in Section 7—MCP Comparative Information to review the 2025 Iowa Health Link MCO Scorecard, which is inclusive of **MOL**'s performance.

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

HSAG performed a comprehensive assessment of **MOL**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **MOL**'s overall performance contributed to the Iowa Managed Care Program's progress in achieving the Iowa HHS Medicaid Quality Strategy strategic priorities and objectives. Table 3-36 displays each strategic priority and the EQR activity results that indicate whether the MCO's performance positively (✓), negatively (✗), or minimally (●) impacted the Iowa Managed Care Program's progress toward achieving the applicable strategic priorities and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **MOL**'s Medicaid and Hawki members. Additionally, not applicable (**NA**) was used if an Iowa HHS Medicaid Quality Strategy priority or related objective did not include any quality measures for **MOL**'s programs or the EQR activities did not produce data to assess the impact under an Iowa HHS Medicaid Quality Strategy objective.

Table 3-36—Overall Performance Impact to Iowa HHS Medicaid Quality Strategy and Quality, Timeliness, and Access

Strategic Priority	Overall Performance Impact	Performance Domain
1.0 Access to Care	**Improve Behavioral Health Network Adequacy** ✓ **MOL** achieved rates at or above the 75th percentile for *Follow-Up After Emergency Department Visit for Mental Illness* for both the 7-day and 30-day indicators. **Improve Access to Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to Primary Care and Specialty Care** NA In CY 2025, the *SDOH Screening* PIP was continued, and **MOL** received a designation of *High Confidence* for Validation Rating 1 of the Design phase. However, as only baseline data were reported for this PIP in CY 2025, progress toward achieving the Iowa HHS Medicaid Quality Strategy objective could not be assessed. As this PIP's interventions have the potential to impact this objective, progress will be assessed in future technical reports. NA The NAV EQR activity did not produce sufficient data to assess the impact of provider-to-member ratios for this objective. However, the Iowa HHS	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Medicaid Quality Strategy indicated that HHS would update the network adequacy standards to include minimum required provider-to-member ratios for PCPs and specialists. As such, performance of these measures will be assessed in future technical reports when included as part of the NAV and compliance activities.	
2.0 Whole Person Coordinated Care	**Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis** ✓ **MOL**'s measure rate of 53.97 percent for *Initiation of SUD Treatment—Total* indicated it achieved the Iowa Medicaid Quality Strategy objective to *Increase Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) from 39.2% 45% for initiation by SFY2027*, and demonstrated progress toward meeting the objective to increase engagement of *SUD treatment from 15.5% to 20% by SFY2027* as **MOL** had a measure rate of 17.68 percent for the measure *Engagement of SUD Treatment—Total*. ✓ **MOL**'s measure rate for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* for MY 2024 was 79.76 percent, indicating that it is making progress toward meeting the Iowa HHS Medicaid Quality Strategy objective to *Increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% by SFY2027*. ✗ **MOL**'s performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total measure rate for* MY 2024 (25.53 percent) indicated it did not make progress toward meeting the Iowa HHS Medicaid Quality Strategy objective to *Increase Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose and Cholesterol), (APM) from 23.6% to 30% by SFY2027*. Of note, **MOL** was a new MCO effective July 1, 2023; therefore, year-over-year performance was not included in this assessment.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Improve Prenatal and Postpartum Comprehensive Care Management ✓ **MOL**'s performance for the *Prenatal and Postpartum Care* measure rates were 80.54 percent, indicating that the MCO positively impacted the Iowa HHS Medicaid Quality Strategy objectives to *Increase prenatal visits in the first trimester by 5% (59%) by SFY2027 and increase Postpartum visits from 5% (32%) by SFY2027.* While the MCO demonstrated it met the performance benchmarks set by HHS, the MCO's rate for the *Timeliness of Prenatal Care* indicator was below the 25th national percentile, and the *Postpartum Care* indicator rate was at or above the 25th percentile but below the 50th percentile, indicating continued opportunities for improvement. **Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services** NA *LTSS-6: LTSS Admission to a Facility from the Community*—While data were reported and validated through the PMV activity for three indicators, benchmarks for this measure have not been established by HHS so **MOL**'s impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity. NA *LTSS-7: LTSS Minimizing Facility Length of Stay*—**MOL** had a denominator that was too small to report a valid rate. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity. NA *LTSS-8: LTSS Successful Transition After Long-Term Facility Stay*—**MOL** had a denominator that was too small to report a valid rate. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity.	

Strategic Priority	Overall Performance Impact	Performance Domain
3.0 Health Equity	**Address Disparities in Behavioral Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Primary and Specialty Care Services** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☒ Timeliness ☒ Access
4.0 Program Administration	**Grievances, Appeals, and Exception to Policy** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access
5.0 Voice of the Customer	✓ Through the 2025 CAHPS activity, **MOL** achieved a score that was statistically significantly higher than the 2024 national average for one of the general composite measures (*Getting Care Quickly*) for the general child Medicaid population and the CCC Medicaid supplemental population. ✓ Through the 2025 CAHPS activity, **MOL** achieved a score that was statistically significantly higher than the 2024 national average for one of the CCC composite measure items (*FCC: Getting Needed Information*) for the CCC Medicaid supplemental population. • **MOL**'s score for *Rating of All Health Care* for the general child Medicaid population was 72.60 percent, which was not statistically significantly higher or lower than the national average. Therefore, minimal impact was made on the objective to *Use the national average as a benchmark for CAHPS survey questions*.	☒ Quality ☐ Timeliness ☐ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	✗ Through the 2025 CAHPS activity, **MOL** achieved a score that was statistically significantly lower than the 2024 national average for one of the global ratings (*Rating of Health Plan*) for the adult Medicaid population, general child Medicaid population, and CCC Medicaid supplemental population, indicating an area of opportunity for improvement across all populations. NA The 2025 CAHPS activity did not produce data to assess the impact of *Rating of Specialist Seen Most Often* global rating for the general child Medicaid and CCC Medicaid supplemental populations; the *Customer Service* composite measure for the adult Medicaid, general child Medicaid, and CCC Medicaid supplemental populations; and the *Discussion Cessation Strategies* measure for the adult Medicaid population. A minimum of 100 responses was not obtained for these measures; therefore, results could not be reported.	

Wellpoint Iowa, Inc.

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **WLP**'s PIP (i.e., the PIP Design and Implementation stage). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-37 displays the validation ratings and performance indicators.

Table 3-37—Overall Validation Rating for WLP

PIP Topic	Validation Rating 1*	Validation Rating 2*	Performance Indicator	Performance Indicator Results		
				Baseline	R1	R2
Nonclinical PIP: *SDOH Screening*	*Low Confidence*	*Not Assessed*	The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.	20.8%	—	—
			The percentage of existing enrolled members who received a subsequent screening for SDOH during the measurement period.	14.1%	—	—
Clinical PIP: *Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)*	*Low Confidence*	*Not Assessed*	Members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.	48.7%	—	—
			Members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	53.8%	—	—

Validation Rating 1 = Overall confidence of adherence to acceptable methodology for all phases of the PIP.
Validation Rating 2 = Overall confidence that the PIP achieved significant improvement.
R1 = Remeasurement 1
R2 = Remeasurement 2
Gray shading with a dash (—) = The PIP had not progressed to reporting R1, or R2 results during SFY 2025.
* Based on the scores assigned for individual evaluation elements in the PIP Validation Tool and the confidence level definitions provided in Appendix A.
** Not Assessed—HSAG did not assess Validation Rating 2 for CY 2025 as the MCO reported the Design and Implementation stage for each PIP.

The goal for both PIPs is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Table 3-38 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MCO to support achievement of the PIP goals and address the barriers.

Table 3-38—Barriers and Interventions for WLP

SDOH Screening	
Barriers	**Interventions**
Provider engagement, incorrect member information, and lack of member access to internet/no capabilities/member knowledge/most at-risk members.	Social driver of health provider incentive program.
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	
Barriers	**Interventions**
Lack of provider engagement, members missing follow-up visits, claims concerns, and provider education of measure/required components for compliance and claims issues/concerns.	ADD was added to the Provider Quality Incentive Program/Shared Savings Program.
Member engagement and members missing follow-up visits.	Member SMS texting campaign.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: WLP created sound PIP designs and has the foundation to progress to subsequent PIP stages. [**Quality**]

Weaknesses and Recommendations

Weakness #1: WLP had opportunities for improvement specific to developing and describing interventions that address the identified barrier to care and methods to evaluate the effectiveness of each effort. [**Quality** and **Access**]

Why the weakness exists: The documentation submitted did not clearly describe each intervention and the intervention addressed root causes/barriers identified through data analysis and QI tools.
Recommendation: HSAG recommends that **WLP** clearly describe how each intervention will address each associated barrier to care and develop intervention evaluation measures to capture the impact of the intervention effort.

Performance Measure Validation

Performance Results

PMV

HSAG reviewed **WLP**'s eligibility and enrollment data system, claims and encounter data processing system, provider data system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, **WLP** demonstrated it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report accurate encounter data and performance measure rates to HHS. However, during the audit HSAG identified multiple misalignments between **WLP**'s source code and the technical specifications. **WLP** corrected its source code and underwent additional primary source verification. All records reviewed aligned with the data output files and the measure specifications for performance measure calculation. **WLP** was able to report valid and reportable rates. Table 3-39 displays the indicator rates for each performance measure reported by **WLP**.

Table 3-39—WLP MY 2024 MLTSS Performance Measures

	LTSS Performance Measures	Denominator	Numerator	Performance Measure Rate
Medicaid MLTSS Admission to a Facility from the Community (MLTSS-6)				
1.	*Short-Term Stay—18–64 Years*	91,461	249	2.72
	Short-Term Stay—65–74 Years	35,869	80	2.23
	Short-Term Stay—75–84 Years	25,021	31	1.24
	Short-Term Stay—85+ Years	18,441	12	0.65
	Medium-Term Stay—18–64 Years	91,461	72	0.79
	Medium-Term Stay—65–74 Years	35,869	91	2.54
	Medium-Term Stay—75–84 Years	25,021	46	1.84
	Medium-Term Stay—85+ Years	18,441	23	1.25
	Long-Term Stay—18–64 Years	91,461	14	0.15
	Long-Term Stay—65–74 Years	35,869	22	0.61
	Long-Term Stay—75–84 Years	25,021	9	0.36
	Long-Term Stay—85+ Years	18,441	14	0.76
Medicaid MLTSS Minimizing Facility Length of Stay (MLTSS-7)				
2.	*Observed Rate*	646	309	47.83%
	Risk-Adjusted Rate	646	216.0381	33.44%
	O/E Ratio	216.0381	309	1.4303

LTSS Performance Measures		Denominator	Numerator	Performance Measure Rate
Medicaid MLTSS Successful Transition After Long-Term Facility Stay (MLTSS-8)				
3.	*Observed Rate*	238	133	55.88%
	Risk-Adjusted Rate	238	166.2339	69.85%
	O/E Ratio	166.2339	133	0.8001

HEDIS

HSAG's review of the FAR for HEDIS MY 2024 showed that **WLP**'s HEDIS compliance auditor found **WLP**'s information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. **WLP** contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. Table 3-40 displays the indicator rates for each HEDIS MY 2024 performance measure reported by **WLP**.

Table 3-40—HEDIS MY 2024 Results for WLP

Measures	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Three-Year Trend	Star Rating
Access to Preventive Care					
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	77.91%	81.26%	81.24%	↑	★★★★
45–64 Years	84.36%	87.29%	87.16%	↑	★★★★
65+ Years	91.71%	95.45%	96.06%	↑	★★★★★
Use of Imaging Studies for Low Back Pain					
Total	69.97%	67.02%	66.14%	↓	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI percentile—Total	81.19%	79.56%	80.54%	↓	★★
Counseling for Nutrition—Total	69.59%	66.42%	61.56%	↓	★
Counseling for Physical Activity—Total	66.75%	63.26%	57.91%	↓	★
Women's Health					
Breast Cancer Screening					
Breast Cancer Screening	NR	56.07%	57.72%	—	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	—	NR	56.53%	—	★★★
Chlamydia Screening in Women					
Total	46.68%	44.89%	43.95%	↓	★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	89.51%	88.08%	83.70%	↓	★★
Postpartum Care	82.62%	83.70%	83.21%	↑	★★★

Measures	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Three-Year Trend	Star Rating
Living With Illness					
Glycemic Status Assessment for Patients With Diabetes					
Glycemic Status <8.0%	62.29%	64.48%	64.48%	↑	★★★
*Glycemic Status >9.0%**	27.49%	27.25%	28.47%	↓	★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	77.86%	81.75%	77.86%	↔	★★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	59.37%	59.85%	61.07%	↑	★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	68.13%	71.29%	73.24%	↑	★★★★
Statin Therapy for Patients With Cardiovascular Disease					
Received Statin Therapy—Total	81.24%	80.99%	81.74%	↑	★★★
Statin Therapy for Patients With Diabetes					
Received Statin Therapy	65.21%	67.68%	67.18%	↑	★★★
Behavioral Health					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	72.16%	75.47%	76.34%	↑	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.08%	81.38%	83.29%	↑	★★★
Follow-Up After Emergency Department Visit for Substance Use					
7-Day Follow-Up—Total	59.35%	49.30%	37.89%	↓	★★★★
30-Day Follow-Up—Total	69.09%	60.75%	51.09%	↓	★★★★
Follow-Up After Emergency Department Visit for Mental Illness					
7-Day Follow-Up—Total	65.45%	70.81%	63.61%	↓	★★★★★
30-Day Follow-Up—Total	76.06%	81.66%	78.00%	↑	★★★★★
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	63.54%	67.73%	68.08%	↑	★★★★★
30-Day Follow-Up—Total	79.03%	81.78%	82.71%	↑	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment					
Initiation of SUD Treatment—Total—Total	65.28%	49.83%	49.74%	↓	★★★
Engagement of SUD Treatment—Total—Total	24.17%	19.43%	19.13%	↓	★★★

Measures	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Three-Year Trend	Star Rating
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose and Cholesterol Testing—Total	NR	NR	29.40%	—	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	62.92%	61.18%	65.33%	↑	★★★
Keeping Kids Healthy					
Childhood Immunization Status					
Combination 3	71.78%	69.59%	75.91%	↑	★★★★★
Combination 10	42.09%	36.98%	33.09%	↓	★★★
Immunizations for Adolescents					
Combination 1	83.94%	86.62%	88.08%	↑	★★★★
Combination 2	35.77%	31.39%	30.41%	↓	★
Lead Screening in Children					
Lead Screening in Children	73.72%	77.86%	83.21%	↑	★★★★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	62.75%	67.39%	67.41%	↑	★★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	68.46%	72.19%	75.69%	↑	★★★
Child and Adolescent Well-Care Visits					
Total	49.65%	54.62%	57.93%	↑	★★★
Medication Management					
Statin Therapy for Patients With Cardiovascular Disease					
Statin Adherence 80%—Total	71.71%	69.01%	73.06%	↑	★★★
Statin Therapy for Patients With Diabetes					
Statin Adherence 80%	69.92%	66.42%	69.82%	↓	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.78%	67.54%	72.76%	↑	★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	62.38%	65.35%	58.78%	↓	★★
Effective Continuation Phase Treatment	44.24%	46.04%	42.68%	↓	★★
Appropriate Testing for Pharyngitis					
Total	80.61%	87.13%	87.71%	↑	★★★
Asthma Medication Ratio					
Total	67.36%	66.25%	64.47%	↓	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Total	56.12%	56.97%	54.51%	↓	★★

Measures	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Three-Year Trend	Star Rating
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	NR	NR	48.74%	—	★★★
Continuation and Maintenance Phase	NR	NR	53.75%	—	★★
Appropriate Treatment for Upper Respiratory Infection					
Total	89.71%	87.61%	87.93%	↓	★★
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	83.68%	57.69%	57.41%	↓	★★★
Pharmacotherapy Management of COPD Exacerbation					
Bronchodilator	79.66%	79.18%	80.51%	↑	★★
Systemic Corticosteroid	75.21%	72.35%	72.12%	↓	★★★
Use of Opioids at High Dosage*					
Use of Opioids at High Dosage	2.34%	2.66%	2.81%	↓	★★★
Use of Opioids From Multiple Providers*					
Multiple Pharmacies	1.24%	1.66%	1.93%	↓	★★★
Multiple Prescribers	17.09%	17.55%	18.60%	↓	★★★
Multiple Prescribers and Multiple Pharmacies	0.88%	0.99%	1.53%	↓	★★★

* For this indicator, a lower rate indicates better performance.
—This symbol indicates that NCQA recommended a break in trending; therefore, the rate is not displayed.
"NR" indicates that measure rate was not reported.
↓ Indicates performance worsened over a three-year time period.
↑ Indicates performance improved over a three-year time period.
↔ Indicates performance remained stable over a three-year time period.
HEDIS MY 2024 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★ = At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: WLP's performance in the Living with Illness domain remained strong for *Blood Pressure Control for Patients With Diabetes* and *Controlling High Blood Pressure* measure indicators, both of which finished at or above the 75th percentile. [**Quality**]

Strength #2: WLP's performance in the Behavioral Health domain remained strong for the *Follow-Up After Emergency Department Visit for Substance Use* measure indicator, which finished at or above the 75th percentile, and the *Follow-Up After Hospitalization for Mental Illness* measure indicator, which finished at or above the 90th percentile. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Within the Access to Preventive Care domain, **WLP**'s rates for *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* and *45–64 Years* measure indicators finished at or above the 75th percentile, while the *65+ Years* measure indicator finished at or above the 90th percentile. [**Quality** and **Access**]

Strength #4: WLP demonstrated multiple methods of validation and tracking to ensure the accuracy of enrollment data, claim adjudication, and claim conversion into 837 encounter files for submission to HHS. [**Quality**]

Strength #5: WLP was receptive to clarification regarding MLTSS measure definitions. **WLP** demonstrated a willingness to learn in order to improve its accuracy of rate reporting. [**Quality**]

Weaknesses and Recommendations

Weakness #1: WLP's performance in the Access to Preventive Care domain remained low, as the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* measure indicators ranked below the 25th percentile. [**Quality**]

Why the weakness exists: Low rates suggest **WLP**'s providers are missing opportunities to provide preventive information to child and adolescent members and caregivers, which can lead to negative health outcomes and higher healthcare costs.

Recommendation: HSAG recommends that **WLP** identify data trends to identify providers with nutrition and physical activity counseling gaps, and target outreach to these providers to provide best practices regarding counseling during office visits.

Weakness #2: WLP's performance in the Women's Health domain remained low, as the *Chlamydia Screening in Women* measure ranked below the 25th percentile. [**Quality**]

Why the weakness exists: Low screening rates suggest that barriers continue to exist for sexually active women 16 to 24 years of age in accessing this important health screening, or potentially may stem from missed opportunities during in-office visits, such as those for pregnancy testing, contraception services, annual exams, or when addressing members with a history of sexual abuse or prior sexually transmitted infections.

Recommendation: WLP reported initiatives, including increased communication with providers regarding HEDIS measures and best practices, and the addition of targeted HEDIS measures in

value-based contracts for improvement areas. HSAG recommends that **WLP** research specific interventions, including provider and member outreach and education.

Weakness #3: Within the Behavioral Health domain, **WLP**'s rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* indicator ranked below the 25th percentile. [**Quality**]

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

Recommendation: HSAG recommends that **WLP** assess how providers are coordinating on antipsychotic care and encourage joint PCP and mental health provider monitoring to potentially increase the rate of metabolic monitoring. Further, HSAG recommends that **WLP** evaluate if any potential enhancements can be made to provider data reports to clearly identify trends in whether providers are prescribing antipsychotics without metabolic monitoring.

Weakness #4: Within the Keeping Kids Healthy domain, **WLP**'s rate for *Childhood Immunization Status—Combination 10* measure indicator finished below the 25th percentile. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Low immunization rates may be due to disparities within **WLP**'s population that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status.

Recommendation: HSAG recommends that **WLP** evaluate any member-level detail data provided to providers to verify accuracy and support ongoing QI efforts. Additionally, **WLP** should explore partnering with contracted providers to support bi-directional data exchange of noncompliant members for provider-focused, targeted outreach to support gap closure.

Weakness #5: During source code review and PSV, HSAG noted multiple areas of specification misalignment, specifically for participant month calculations, required exclusions, length of stay calculations, and anchor date inclusion. **WLP** noted difficulties with interpreting the MLTSS specifications for source code creation and validation. [**Quality**]

Why the weakness exists: **WLP** appeared to misinterpret the specifications when programming its source code.

Recommendation: For future reporting, HSAG recommends that **WLP** consult with CMS via the MLTSS technical assistance mailbox to obtain measure clarifications or technical assistance with calculating and reporting these measures.

Weakness #6: During PSV, **WLP** noted that multiple facility stays were not included in its measure calculations, as the billed UB codes did not align with the required MLTSS measures value sets. **WLP** confirmed that the billed UB codes aligned with HHS' billable codes, per HHS' *Informational Letter 2601-MC-FFS Revenue Code Billing for Managed Care Organization (MCO) Claims* and UB claim form instructions. [**Quality**]

Why the weakness exists: **WLP** has not explored the potential use of codes not included in the measure value set by mapping to allowable value set codes.

Recommendation: HSAG suggests that **WLP** consult with HHS to understand whether any of the billable codes not included in the MLTSS measures value set can be accurately mapped to the allowable value set codes for future audits. HSAG also recommends that **WLP** work in conjunction with its contracted facilities to provide insight regarding codes within the MLTSS measures value set and to ensure billed codes accurately represent the code subcategory for facility stays of each member.

Compliance Review

Performance Results

Table 3-41 presents an overview of the results of the standards reviewed during the CY 2025 compliance review for **WLP**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **WLP** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-41—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	20	20	16	4	0	**80%**
Standard IX—Confidentiality	21	21	18	3	0	**86%**
Standard X—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard XI—Subcontractual Relationships and Delegation	7	7	5	2	0	**71%**
Standard XII—Practice Guidelines	6	6	6	0	0	**100%**
Standard XIII—Health Information Systems	9	9	8	1	0	**89%**
Standard XIV—Quality Assessment and Performance Improvement Program	19	19	19	0	0	**100%**
Total	**120**	**120**	**104**	**16**	**0**	**87%**

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Strength #2: WLP achieved full compliance for the Quality Assessment and Performance Improvement Program area, demonstrating that the MCO had adequate procedures and processes in place to support the provision of quality services to its members, maintain sufficient quality monitoring activities to assess ongoing performance, and conduct timely implementation of strategies to mitigate identified opportunities for improvement. [**Quality**]

Weaknesses and Recommendations

Weakness #1: WLP had four elements in the Provider Selection program area that received a score of *Not Met*, indicating that the MCO had not followed its internal processes and procedures for timely credentialing and recredentialing of providers. [**Timeliness**]
Why the weakness exists: Through a review of case files, gaps in **WLP**'s processes were identified related to verification of State sanctions, timely completion of credentialing and recredentialing of providers, and conducting timely on-site quality assessments.
Recommendation: While **WLP** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO enhance its processes to ensure all providers are credentialed and recredentialed in a timely manner and verifications occur as required.

Weakness #2: WLP had three elements in the Confidentiality program area that received a score of *Not Met*, indicating that the MCO did not have adequate processes in place to ensure compliance with all privacy requirements stipulated in 45 CFR parts 160 and 164, subparts A and E. [**Quality**]
Why the weakness exists: Through a review of written policies and procedures and MCO-submitted samples, gaps in **WLP**'s processes were identified related to signed authorizations provided to members when the MCO sought the authorization (such as through marketing activities), timely notification to members of a breach, and the content of breach notification letters.
Recommendation: While **WLP** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to privacy requirements.

Weakness #3: WLP had six elements in the Grievances and Appeals program area that received a score of *Not Met*, indicating that the MCO had not implemented a member grievance and appeal process in accordance with all federal and/or contractual requirements. [**Quality**, **Timeliness**, and **Access**]
Why the weakness exists: Through a review of written policies and procedures and case files, gaps in **WLP**'s processes were identified related to timely acknowledgement of grievances and appeals, timely follow-up on grievances, notice of grievance resolution time frame extensions, timely

resolution of grievances, timely oral and written notice of grievance resolution time frame extensions and provision of this information to members, and tracking of timely reinstatement of services.

Recommendation: While **WLP** was required to develop a CAP to address the identified deficiencies, HSAG recommends that the MCO enhance oversight and monitoring of its grievance and appeal processes by conducting a comprehensive review of a random sample of grievance and appeal files and implement corrective action for all identified deficiencies.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MCO according to the CMS EQR Protocol 4 and as defined in Table A-11 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 3-42 presents a summary of the NAV validation ratings for **WLP** by network adequacy standard type.

Table 3-42—Summary of WLP Validation Ratings by Standard Type

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias	Could Not Be Validated
Time/Distance	100%	0%	0%	0%	0%
Minimum Provider Agreements	100%	0%	0%	0%	0%
Appointment Wait Time	75%	0%	0%	0%	25%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 53 indicators for **WLP**. All 15 Time/Distance indicators received a rating of *High Confidence,* all 26 Minimum Provider Agreements received a rating of *High Confidence,* eight Appointment Wait Time indicators received a rating of *High Confidence,* and the remaining four Appointment Wait Time indicators received a rating of *Could Not Be Validated*.

HSAG assessed results submitted by **WLP**, including data reported as of December 31, 2024, representing a snapshot in time and summarizing cumulative network adequacy data collected over the preceding 12 months, and that indicated compliance with the network adequacy time and distance standards. Table 3-43 summarizes the percentage of members with access to the time and distance network adequacy indicators for the most recent available results during the reporting period. The compliance threshold for Primary Care Providers (PCP), General Optometry, Lab and X-ray Services and Pharmacies is 100 percent. The compliance threshold for Specialty Care Providers is access for at least 75 percent of members within 60 minutes or 60 miles and access for at least 99.5 percent of members within 90 minutes or 90 miles. Results that achieved the required percent threshold are shaded green and marked with a plus sign.

Table 3-43—WLP Q2 Percentage of Members With Access Across Time and Distance Indicators

Provider Type	Indicator	Percentage of Members With Access
PCP—Adult	30 minutes or 30 miles from the personal residences of members	100%+
PCP—Pediatric	30 minutes or 30 miles from the personal residences of members	100%+
Allergy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Allergy—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Cardiology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Cardiology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Dermatology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
Dermatology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Endocrinology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Endocrinology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Gastroenterology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.91%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Gastroenterology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.92%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
General Surgery—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
General Surgery—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Hematology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Hematology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Long-Term Care Services—*Institutional Providers:* ICF/ID—Individuals with Intellectual Disabilities—Urban	30 minutes or 30 miles	100%
Long-Term Care Services—*Institutional Providers*: ICF/ID—Individuals with Intellectual Disabilities—Rural	60 minutes or 60 miles	100%
Long-Term Care Services—*Institutional Providers:* ICF/SNF—Skilled Nursing Care Facility—Urban	30 minutes or 30 miles	100%
Long-Term Care Services—*Institutional Providers:* ICF/SNF—Skilled Nursing Care Facility—Rural	60 minutes or 60 miles	100%

Provider Type	Indicator	Percentage of Members With Access
Neonatology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	97.10%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Nephrology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Nephrology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Neurology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Neurology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Neurosurgery—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	97.20%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
OB/GYN—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Occupational Therapy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Oncology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Oncology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Ophthalmology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Ophthalmology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
Orthopedics—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Orthopedics—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Otolaryngology (ENT)—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Otolaryngology (ENT)—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Pathology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Physical Therapy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
Psychiatry—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Pulmonology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Pulmonology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Radiology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Reconstructive Surgery—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	99.40%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Rheumatology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	98.30%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+

Provider Type	Indicator	Percentage of Members With Access
Rheumatology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	98.10%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Speech Therapy—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Urology—Adult	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Urology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	100%+
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	100%+
Hospital	30 minutes or 30 miles	100%+
Behavioral Health—Inpatient—Rural	90 minutes or 90 miles from the personal residence of members	100%+
Behavioral Health—Inpatient—Urban	60 minutes or 60 miles from the personal residence of members	100%+
Behavioral Health—Outpatient	30 minutes or 30 miles from the personal residence of members	100%+
General Optometry	30 minutes or 30 miles	99.99%+
Lab and X-ray Services	30 minutes or 30 miles	98.90%
Pharmacies	30 minutes or 30 miles	100%+

Table 3-44—WLP Q2 Compliance With LTCS-HCBS Minimum Providers per County

Provider Type	Indicator	Compliance
Long-Term Care Services—HCBS [Home- and Community-Based Service] Providers	At least two providers per county for each covered HCBS in the benefit package for each 1915(c) waiver	*Met^*

^Indicates compliance based on an HHS approved exception.

HSAG assessed results submitted by **WLP** that indicated compliance with the minimum provider agreement requirements for all provider types. Compliance was determined based on the MCO meeting HHS' minimum provider agreement standard of at least one provider. Table 3-45 summarizes compliance with the minimum provider agreement indicators for **WLP**.

Table 3-45—WLP Minimum Provider Agreements by Provider Type

Provider Type	Compliance
Allergy	*Met*
Cardiology	*Met*
Dermatology	*Met*
Endocrinology	*Met*
Gastroenterology	*Met*
General Surgery	*Met*
Hematology	*Met*
Neonatology	*Met*
Nephrology	*Met*
Neurology	*Met*
Obstetrics and Gynecology	*Met*
Occupational Therapy	*Met*
Oncology	*Met*
Ophthalmology	*Met*
Orthopedics	*Met*

Provider Type	Compliance
Otolaryngology	*Met*
Pathology	*Met*
Physical Therapy	*Met*
Pulmonology	*Met*
Psychiatry	*Met*
Radiology	*Met*
Reconstructive Surgery	*Met*
Rheumatology	*Met*
Speech Therapy	*Met*
Urology	*Met*
Pediatric Specialties	*Met*

Table 3-46 summarizes **WLP**'s appointment wait time survey results of provider compliance with HHS-defined appointment wait time indicators.

Table 3-46—WLP Percent Within Standard for Appointment Wait Time by Provider Type

Provider Type	Indicator	Percentage Compliant
PCP	4 to 6 weeks for routine care	97%
	48 hours for persistent care	95%
	1 day for urgent care	95%
Specialty Care	30 days for routine care	99%
	1 day for urgent care	56%
Behavioral Health Services—*Emergency*	Seen or referred to an appropriate provider upon presentation	67% Prescribers—Non-Life Threatening 84% Non-Prescribers—Non-Life Threatening 42% Prescribers—Life Threatening 35% Non-Prescribers—Life Threatening
Behavioral Health Services—*Routine*	Seen or referred to an appropriate provider within 3 weeks	64% Prescribers 80% Non-Prescribers

Provider Type	Indicator	Percentage Compliant
Behavioral Health Services—*Substance Use Disorder & Pregnancy*	48 hours	71% Prescribers 96% Non-Prescribers
Behavioral Health Services—*Intravenous Drug Use*	14 days or 120 days if no program has capacity to admin and if interim services are available 48 hours	92% Prescribers 96% Non-Prescribers
Behavioral Health Services—*Urgent*	1 hour of presentation or within 24 hours of telephone contact	57% Prescribers 76% Non-Prescribers
Lab and X-Ray Services	3 weeks regular appointments	80%
	48 hours urgent care	100%

HSAG determined the appointment wait times standards in Table 3-47 required by HHS were not calculated and reported by **WLP**, resulting in an "*Unable to Validate"* rating determination for each associated indicator.

Table 3-47—WLP Appointment Wait Time Indicators *Unable to Validate*

Provider Type	Indicators
General Optometry Services	Not to exceed three weeks for regular appointments and 48 hours for urgent care
Behavioral Health Services—*Mobile Crisis*	Members in need of mobile crisis services shall receive services within one hour of presentation or request
Behavioral Health Services—*Persistent Symptoms*	Members with persistent symptoms shall be seen or referred to an appropriate provider within 48 hours or reporting symptoms

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: WLP continued to demonstrate its ability to fully use its system capabilities for maintaining member and provider data. **WLP** also used automation when possible to limit manual entry errors. [**Quality**]

Strength #2: WLP demonstrated its commitment to data quality by having multiple types of audits in place to ensure the accuracy of both member and provider data. [**Quality**]

Weaknesses and Recommendations

Weakness #1: WLP did not report appointment wait time results for general Optometry services, Behavioral Health—*Mobile Crisis*, Behavioral Health—*Urgent*, and Behavioral Health—*Persistent Symptoms* during the review period. [**Quality**]

Why the weakness exists: WLP did not fully incorporate the State's requirements into its provider survey protocol.

Recommendation: HSAG recommends that **WLP** continue with its plan to implement its updated reporting template and survey script to include results for all required provider types.

Weakness #2: For several provider types, some time/distance indicators were considered "met" based on an approved exception from HHS due to factors such as a lack of available providers. [**Access**]

Why the weakness exists: Persistent provider shortages in certain specialties and geographic areas limited **WLP**'s ability to meet standard time/distance requirements without exceptions.

Recommendation: HSAG recommends that **WLP** continue to focus on solutions it has found to be effective in expanding its provider network, including monitoring of the state waiver service file to identify LTCS providers and notifications by HHS regarding new providers joining the Medicaid program.

Encounter Data Validation

Performance Results

Representatives from **WLP** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to HHS.

Table 3-48 outlines the key findings for **WLP** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from July 1, 2023, through June 30, 2024.

Table 3-48—EDV Summary of Key Findings: WLP

Analysis	Key Findings
Medical Record Review	
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate for **WLP** was slightly low at 89.5 percent, indicating that more than 10.0 percent of requested records were not procured and submitted. • All submitted records were deemed valid and reviewed by HSAG.
Second Date of Service Submission Rate	• Among the requested sampled records, 49.6 percent included a corresponding second date of service. Of these records, HSAG reviewed 82.8 percent.
Encounter Data Completeness	
Medical Record Omission Rate	• While the medical record omission rate for the *Procedure Code Modifier* data element was above 10.0 percent (at 12.6 percent), medical record omission rates for the remaining data elements were below 10.0 percent, ranging from 7.5 percent (*Date of Service*) to 9.1 percent (*Diagnosis Code*).
Encounter Data Omission Rate	• All encounter data omission rates were below 10.0 percent, ranging from 0.7 percent (*Date of Service* and *Diagnosis Code*) to 4.4 percent (*Procedure Code*).

Analysis	Key Findings
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The accuracy rate for the *Diagnosis Code* data element was 99.6 percent. The most common error type was related to inaccurate coding (83.3 percent).
Procedure Code Accuracy Rate	• The accuracy rate for the *Procedure Code* data element was 98.1 percent. The most common error type was related to inaccurate coding (57.1 percent).
Procedure Code Modifier Accuracy Rate	• The accuracy rate for the *Procedure Code Modifier* data element was 100 percent.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in 82.9 percent of dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: A high proportion of *Date of Service*, *Diagnosis Code*, and *Procedure Code* data elements reported in the encounter data were supported by the members' medical records, as evidenced by medical record omission rates below 10.0 percent for these data elements. [**Quality**]

Strength #2: Key data elements documented in members' medical records were generally captured in the encounter data, as evidenced by low encounter data omission rates across all evaluated data elements (i.e., 4.4 percent or below for the *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data elements). [**Quality**]

Strength #3: When present in both the encounter data and members' medical records and evaluated independently, the key data element values were found to be accurate with rates of at least 98.1 percent each. [**Quality**]

Weaknesses and Recommendations

Weakness #1: WLP exhibited a low medical record procurement rate, which limited the availability of documentation to validate encounter data for sampled dates of service. [**Quality**]

Why the weakness exists: The lower procurement rate was largely driven by provider non-responsiveness or delayed responses to medical record requests. In some instances, providers did not submit records within the required timeframe or submitted incomplete documentation, reducing the proportion of records available for review.

Recommendation: WLP should strengthen its medical record procurement processes by reinforcing provider accountability for timely and complete medical record submission. This may include enhancing contractual requirements, implementing escalation procedures for non-responsive providers, and conducting targeted outreach to providers with repeated noncompliance. Improving procurement rates would increase the completeness of documentation available for validation and reduce medical record omission rates in future reviews.

Weakness #2: The medical record omission rate for the *Procedure Code Modifier* data element was elevated at 12.6 percent, indicating that a notable proportion of procedure code modifiers reported in the encounter data were not supported by documentation in members' medical records.

Why the weakness exists: The elevated omission rate for the *Procedure Code Modifier* data element was primarily attributable to documentation gaps, including instances in which medical records lacked sufficient detail to support the reported modifiers. Additionally, medical record non-submission or records that did not support the sampled date of service resulted in all associated procedure code modifiers being treated as medical record omissions, further contributing to the elevated rate.

Recommendations: WLP should enhance its provider education and oversight related to procedure code modifier documentation, emphasizing modifier-specific documentation requirements and expectations. **WLP** should consider performing targeted reviews of encounters with modifiers, providing provider-specific feedback, and incorporating modifier-focused validation checks into existing auditing or quality assurance processes to improve documentation support and reduce omission rates in future MRR cycles.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-49 presents **WLP**'s 2025 adult Medicaid, general child Medicaid, and CCC Medicaid CAHPS top-box scores. Arrows (↓ or ↑) indicate 2025 scores that were statistically significantly higher or lower than the 2024 national average.

Table 3-49—Summary of CY 2025 CAHPS Top-Box Scores for WLP

	2025 Adult Medicaid	2025 General Child Medicaid	2025 CCC Medicaid Supplemental
Composite Measures			
Getting Needed Care	86.75% ↑	90.59% ↑	87.54% ↑
Getting Care Quickly	83.94%	92.62% ↑	91.43% ↑
How Well Doctors Communicate	97.45% ↑	96.09% ↑	96.00% ↑
Customer Service	86.67%	NA	84.91%
Global Ratings			
Rating of All Health Care	54.38%	68.79%	63.78%
Rating of Personal Doctor	70.50%	77.60%	78.69%
Rating of Specialist Seen Most Often	58.45% ↓	74.77%	76.68%
Rating of Health Plan	58.06%	64.50% ↓	60.49% ↓
Medical Assistance With Smoking and Tobacco Use Cessation Items*			
Advising Smokers and Tobacco Users to Quit	75.74%	—	—
Discussing Cessation Medications	44.97% ↓	—	—
Discussing Cessation Strategies	43.20%	—	—
CCC Composite Measures/Items			
Access to Specialized Services	—	—	75.67%
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	—	91.29%
Coordination of Care for Children With Chronic Conditions	—	—	75.13%
Access to Prescription Medicines	—	—	92.37% ↑
FCC: Getting Needed Information	—	—	92.41%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as "NA" (i.e., Not Applicable).
* These scores follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2025 score is statistically significantly higher than the 2024 national average.
↓ Indicates the 2025 score is statistically significantly lower than the 2024 national average.
— Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: WLP's 2025 top-box scores were statistically significantly higher than the 2024 NCQA adult Medicaid national averages for the following measures: *Getting Needed* and *How Well Doctors Communicate*. **[Quality** and **Access]**

Strength #2: WLP's 2025 top-box scores were statistically significantly higher than the 2024 NCQA child Medicaid national averages for the following measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. **[Quality**, **Timeliness**, and **Timeliness]**

Strength #3: WLP's 2025 top-box scores were statistically significantly higher than the 2024 NCQA CCC Medicaid national averages for the following measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Access to Prescription Medicines*. **[Quality**, **Timeliness**, and **Access]**

Weaknesses and Recommendations

Weakness #1: WLP's 2025 top-box scores were statistically significantly lower than the 2024 NCQA adult Medicaid national averages for the following measures: *Rating of Specialist Seen Most Often* and *Discussing Cessation Medications*. **[Quality]**

Why the weakness exists: When compared to national benchmarks, the results indicate that adult members did not rate the specialist they saw most often or discussions about cessation medications highly.

Recommendation: HSAG recommends that **WLP** conduct provider education to ensure providers document conversations about cessation medications sufficiently and use appropriate billing codes to do so. Additionally, HSAG recommends that **WLP** regularly collect feedback from members throughout the year through town hall meetings, focus groups, and short surveys. For example, members could be sent a short survey following an appointment with a specialist to ask about the timeliness and quality of care received. **WLP** might also conduct research if any specialty type does not meet network adequacy standards, which would impact access to care.

Weakness #2: WLP's 2025 top-box scores were statistically significantly lower than the 2024 NCQA child Medicaid and CCC Medicaid national averages for one measure, *Rating of Health Plan*. **[Quality]**

Why the weakness exists: When compared to national benchmarks, the results indicate that parents/caretakers of child members in the general child and CCC Medicaid population did not rate their experience with their health plan highly.

Recommendation: HSAG recommends that **WLP** conduct a key driver analysis to determine if specific aspects of care drive lower levels of experience with the member's health plan. This process could include analyzing visit appointment records to assess missed appointments, telephone logs, and compliant records. Additionally, **WLP** might conduct research if access to primary care does not meet network adequacy standards, which would impact access to care.

Scorecard

The 2025 Iowa Managed Care Program MCO Scorecard was designed to compare MCO-to-MCO performance using HEDIS and CAHPS measure indicators. As such, MCO-specific results are not included in this section. Refer to the Scorecard activity in Section 7—MCP Comparative Information to review the 2025 Iowa Health Link MCO Scorecard, which is inclusive of **WLP**'s performance.

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

HSAG performed a comprehensive assessment of **WLP**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **WLP**'s overall performance contributed to the Iowa Managed Care Program's progress in achieving the Iowa HHS Medicaid Quality Strategy strategic priorities and objectives. Table 3-50 displays each strategic priority and the EQR activity results that indicate whether the MCO's performance positively (✓), negatively (✗), or minimally (●) impacted the Iowa Managed Care Program's progress toward achieving the applicable strategic priorities and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **WLP**'s Medicaid and Hawki members. Additionally, not applicable (**NA**) was used if an Iowa HHS Medicaid Quality Strategy priority or related objective did not include any quality measures for **WLP**'s programs or the EQR activities did not produce data to assess the impact under an Iowa HHS Medicaid Quality Strategy objective.

Table 3-50—Overall Performance Impact to Iowa HHS Medicaid Quality Strategy and Quality, Timeliness, and Access

Strategic Priority	Overall Performance Impact	Performance Domain
1.0 Access to Care	**Improve Behavioral Health Network Adequacy** ✓ **WLP** achieved rates at or above the 90th percentile for *Follow-Up After Hospitalization for Mental Illness* for both the 7-day and 30-day indicators. ✓ **WLP** achieved rates at or above the 90th percentile for *Follow-up After Emergency Department Visit for Mental Illness* for both the 7-day and 30-day indicators. **Improve Access to Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to Primary Care and Specialty Care** NA During CY 2025, the *SDOH Screening* PIP was continued, and **WLP** received a designation of *Low Confidence* for Validation Rating 1. However, as only baseline data were reported for this PIP during CY 2025, progress toward achieving the Iowa HHS Medicaid Quality Strategy objective could not be assessed. As this PIP's interventions have the potential to impact this objective, progress will be assessed in future technical reports.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	NA The NAV EQR activities did not produce data to assess the impact of provider-to-member ratios for this objective. However, as the Iowa HHS Medicaid Quality Strategy indicated that HHS would update the network adequacy standards to include minimum required provider-to-member ratios for PCPs and specialists. As such, performance of these measures will be assessed in future technical reports when included as part of the NAV and compliance activities.	
2.0 Whole Person Coordinated Care	**Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis** ✓ **WLP**'s performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure rate for MY 2024 (29.40 percent) indicated that it was close to achieving the Iowa HHS Medicaid Quality Strategy objective to *Increase Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose and Cholesterol), (APM) from 23.6% to 30% by SFY2027*. ✓ **WLP**'s performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate for MY 2024 (83.29 percent) indicated that it met the Iowa HHS Medicaid Quality Strategy objective to *Increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% by SFY2027*. ✓ **WLP**'s measure rate of 49.74 percent for *Initiation of SUD Treatment—Total* indicated achievement of the Iowa HHS Medicaid Quality Strategy objective to *Increase Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) from 39.2% to 45% for initiation by SFY2027.* ✗ **WLP**'s measure rate of 19.13 percent for *Engagement of SUD Treatment—Total* indicated no progress toward achieving the Iowa HHS Medicaid Quality Strategy objective to *Increase Engagement of Substance Use Disorder Treatment (IET-AD) from 15.5% to 20% for engagement by SFY2027* as performance fell slightly from the previous year's rate.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Improve Prenatal and Postpartum Comprehensive Care Management ✓ **WLP**'s measure rate of 83.70 percent for *Timeliness of Prenatal Care* and 83.21 percent for *Postpartum Care* demonstrated that it achieved the Iowa HHS Medicaid Quality Strategy objectives to *Increase prenatal visits in the first trimester by 5% (59%) by SFY2027* and *increase Postpartum visits from 5% (32%) by SFY2027*. **Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services** NA *LTSS-6: LTSS Admission to a Facility from the Community*—While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS so **WLP**'s impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity. NA *LTSS-7: LTSS Minimizing Facility Length of Stay*—While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS so **WLP**'s impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity. NA *LTSS-8: LTSS Successful Transition After Long-Term Facility Stay*—While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS so **WLP**'s impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity.	
3.0 Health Equity	**Address Disparities in Behavioral Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Address Disparities in LTSS Services NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Primary and Specialty Care Services** NA The EQR activities did not produce data to assess the impact of this objective.	
4.0 Program Administration	**Grievances, Appeals, and Exception to Policy** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access
5.0 Voice of the Customer	✓ Through the 2025 CAHPS activity, **WLP** achieved a score that was statistically significantly higher than the 2024 national average for three of the general composite measures (*Getting Needed Care, Getting Care Quickly*, and *How well Doctors Communicate*) for the general child Medicaid population and the CCC Medicaid supplemental population, which aligned with the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions.* ✓ Through the 2025 CAHPS activity, **WLP** achieved a score that was statistically significantly higher than the 2024 national average for two of the general composite measures (*Getting Needed Care* and *How Well Doctors Communicate)* for the adult Medicaid population, which aligned with the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions.* • **WLP**'s score for *Rating of All Health Care* for the general child Medicaid population was 68.79 percent, which was not statistically higher or lower than the national average. Therefore, minimal impact was made on the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. ✗ For the adult Medicaid population, **WLP** had a score for the *Rating of Specialist Seen Most Often* of 58.45	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	percent, which was statistically significantly lower than the 2024 national average, indicating a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. Of note, the MCO did not score significantly higher or lower than the 2024 national average for the general child Medicaid population and the CCC Medicaid supplemental population. ✗ **WLP** received a score of 44.97 percent for *Discussing Cessation Medications* for the adult Medicaid population, which was statistically significantly lower than the 2024 national average, indicating a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. NA The EQR activities did not produce sufficient data to assess the impact of this objective. **WLP** did not have a minimum of 100 responses for the *Customer Service* measure for the general child Medicaid population. Performance of this measure will be assessed in future technical reports as part of the CAHPS activity.	

4. Assessment of Prepaid Ambulatory Health Plan Performance

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2025 review period to evaluate the performance of PAHPs on providing quality, timely, and accessible healthcare services to DWP and Hawki members. Quality, as it pertains to EQR, means the degree to which the PAHPs increased the likelihood of members' desired outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to HHS' network adequacy standards) and §438.206 (adherence to HHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the PAHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in CY 2025 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A. Table 4-1 provides HSAG's timeline for conducting each of the EQR activities.

Table 4-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
PIPs	September 5, 2025	January 13, 2026
PMV	August 4, 2025	January 30, 2026

Activity	EQR Activity Start Date	EQR Activity End Date
Compliance Review	May 5, 2025	November 21, 2025
NAV	April 2, 2025	February 13, 2026
EDV	May 22, 2025	February 2, 2026

Validation of Performance Improvement Projects

For the CY 2025 validation, the PAHPs continued the HHS-mandated PIP topic to address annual preventive dental visits, reporting Remeasurement 3 data for the performance indicators. HSAG conducted validation on the PIP Design (Steps 1 through 6, which included a review of each PAHP's selected PIP topic, aim statement, identified population, sampling method, performance indicator(s), and data collection procedures, as applicable), Implementation (Step 7—Review the Data Analysis and Interpretation of PIP Results and Step 8—Assess the Improvement Strategies), and Outcomes (Step 9—Assess the Likelihood that Significant and Sustained Improvement Occurred) stages of the selected PIP topic for each PAHP. Table 4-2 outlines the selected PIP topics and performance indicators for the PAHPs.

Table 4-2—PIP Topics and Performance Indicators

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

Performance Measure Validation

For the EQR time frame under evaluation, HSAG completed PMV activities for **DDIA** and **MCNA** to validate enrollment and eligibility, claims and encounter, provider data processing, and data integration and validation procedures that contribute to CMS Core Set and HHS state-specific reporting. HSAG also validated data integration and measure production processes of an HHS vendor, IBM Watson (IBM), who is contracted with HHS to provide aggregate performance measure rates for all Medicaid populations for CMS Core Set reporting. HSAG validated data from MY 2024 (January 1, 2024–December 31, 2024) for the CMS Core Set measures and SFY 2025 (July 1, 2024–June 30, 2025) for the state-specific performance measures.

Table 4-3 lists the CMS Core Set performance measures validated during the MY 2024 during the PMV activity.

Table 4-3—PAHP Core Set Performance Measures Validated

Performance Measure Name and Indicator	Measure Source
Oral Evaluation, Dental Services	CMS Child Core Set
Sealant Receipt on Permanent First Molars	CMS Child Core Set
Topical Fluoride for Children	CMS Child Core Set

Table 4-4 lists the PAHP state-specific performance measures that HSAG validated, the Iowa populations reported, the method chosen by HHS for data collection, and the specification steward.

Table 4-4—PAHP State-Specific Performance Measures Validated

Performance Measure Name	Program	Method	Required Specification Steward
Members With at Least Six Months of Coverage	DWP, DWP Kids, Hawki	Administrative	HHS
Members Who Accessed Dental Care	DWP, DWP Kids, Hawki	Administrative	HHS
Members Who Received Preventive Dental Care	DWP, DWP Kids, Hawki	Administrative	HHS

Compliance Review

HHS requires its contracted PAHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet mandatory EQR requirements. The compliance reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The current three-year compliance review cycle was initiated in CY 2024 and comprises 14 program areas referred to as standards. At HHS' direction, HSAG conducted a review of the first seven federally

required standards and requirements in Year One (CY 2024) and a review of the remaining federally required seven standards and requirements was reviewed in Year Two (CY 2025) of the three-year compliance review cycle. In CY 2026 (Year Three), the compliance review activity will consist of a re-review of the standards that were not fully compliant during the CY 2024 (Year One) and CY 2025 (Year Two) compliance review activities, as indicated by the elements (i.e., requirements) that received *Not Met* scores and required CAPs to remediate the noted deficiencies. Table 4-5 outlines the standards reviewed over the three-year review cycle.

Table 4-5—Compliance Review Standards

Standard	Associated Federal Citation[1]		Year One (CY 2024)	Year Two (CY 2025)	Year Three (CY 2026)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of each PAHP's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b)	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1110 §457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240(b)		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Part 438 Subpart F).

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

Network Adequacy Validation

In CY 2025, HSAG conducted and completed NAV activities for two PAHPs—**DDIA** and **MCNA**.

States that contract with MCPs to provide Medicaid or CHIP services are required to develop quantitative network adequacy standards across a subset of provider types to set expectations for each contracted MCP's provider networks. States may elect to use a variety of quantitative standards including, but not limited to, minimum provider-to-member ratios, time and distance, percentage of providers accepting new patients, and/or combinations of these quantitative measures. Based on the state-defined network adequacy standards, the State and HSAG defined the network adequacy indicators, which HSAG then validated. The indicators are metrics used to assess adherence to the quantitative network adequacy standards required and set forth by the State. HHS identified network adequacy indicators to be validated for the reporting period(s) during CY 2025, with data reported as of December 31, 2024, for time and distance and minimum provider agreement standards and the most recent data collected since prior year NAV activities as of June 30, 2025, for appointment wait time standards. The results represent a snapshot in time, summarizing cumulative network adequacy data collected over the preceding 12 months. Table 4-6 through Table 4-7 list the network adequacy standards, the indicators that HSAG validated.

Table 4-6—PAHP Network Adequacy Indicators Validated—PAHP Plan Time and Distance Standards

Network Category Description	Time and Distance Standard
Provider Type	
Dentist	30 minutes or 30 miles from the Dental Wellness Plan (DWP) enrollee place of residence
Specialty Care Pediatric Dentist Periodontist Prosthodontist Oral Surgeon Orthodontist Endodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members

Table 4-7—PAHP Network Adequacy Indicators Validated—Appointment Wait Time Standards

Provider Type	Appointment Wait Time
Dentist	Not to exceed six to eight weeks from the date of a patient's request for a routine appointment
	Within 48 hours for persistent symptoms
	Within one day for urgent care
Specialty Care	Within one day for urgent care
	Not to exceed 30 days for routine care

Encounter Data Validation

In CY 2025, HSAG conducted and completed EDV activities for the two PAHPs (i.e., **DDIA** and **MCNA**). The EDV activity included:

- **Comparative analysis**—analysis of HHS' electronic encounter data completeness and accuracy through a comparison between HHS' electronic encounter data and the data extracted from the PAHPs' data systems with dates of service from July 1, 2023, through June 30, 2024.

External Quality Review Activity Results

Delta Dental of Iowa

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **DDIA**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 4-8 displays the validation ratings and performance indicators.

Table 4-8—Overall Validation Rating for DDIA

PIP Topic	Validation Rating 1*	Validation Rating 2*	Performance Indicators	Performance Indicator Results			
				Baseline	R1	R2	R3
Annual Preventive Dental Visits	*High Confidence*	*Moderate Confidence*	1. (DWP adults) The percentage of members 19 years of age and older [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	79.21%	79.05% ⇔	78.74% ↓	75.68% ↓
			2. (Hawki) The percentage of members 18 years of age and younger [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	61.09%	61.94% ↑	59.45% ↓	61.28% ⇔
			3. (DWP kids) The percentage of members 18 years of age and younger [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	49.88%	50.79% ↑	51.18% ↑	52.23% ↑

Validation Rating 1 = Overall confidence of adherence to acceptable methodology for all phases of the PIP.
Validation Rating 2 = Overall confidence that the PIP achieved significant improvement.
R1 = Remeasurement 1
R2 = Remeasurement 2
R3 = Remeasurement 3
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* Based on the scores assigned for individual evaluation elements in the PIP Validation Tool and the confidence level definitions provided in Appendix A.

The goal for **DDIA**'s PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Table 4-9 displays barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the PAHP to support achievement of the PIP goals and address the barriers.

Table 4-9—Remeasurement 2 Barriers and Interventions for DDIA

Barriers	Interventions
Members are calling into the member services helpline multiple times in a short period of time. This creates additional burden on member services staff and creates additional barriers to accessing care and information about member benefits.	Changed its "huddle" structure to ensure all staff who are involved in the call center receive updates and training on a weekly basis.
Young adult DWP members may not understand their benefits, the importance of regular dental services, and effective oral hygiene. Additionally, these members are undergoing many transitions, including moving out of their guardian's homes and moving away to college, which means there is a lack of updated contact information (i.e., phone numbers and addresses) on file for them.	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. Each member in the intervention group received two outreach attempts from a care coordinator with Delta Dental.
Fluoride hesitancy has been cited as a public health problem.	Delta Dental care coordination staff were present at the on-site I-Smile screening days to provide each student with a dental kit that included child and adult oral health materials, and oral health education and activities that included information about fluoride utilization.
Members are unaware of Open Choice period and resources that are available.	Utilization of SmileIA.com as a central landing page for Open Choice education, as well as internal staff resources and training for consistent messaging.
Incorrect addresses among the Medicaid population.	Care coordinators conducted outbound calls to the members to obtain updated information.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: DDIA conducted accurate statistical testing between the baseline and Remeasurement 3 and provided a narrative interpretation of the comparison. The PAHP used appropriate quality improvement tools to conduct its causal/barrier analysis. [**Quality**]

Strength #2: DDIA sustained statistically significant improvement over the baseline for the third performance indicator during the third remeasurement period. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: DDIA demonstrated a statistically significant decrease in performance for the first performance indicator as compared to the baseline. [**Quality**, **Timeliness**, and **Access**]

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

Recommendation: HSAG recommends that **DDIA** consider evidence-based intervention efforts and risk factors in quality of care for the adult population.

Performance Measure Validation

Performance Results

HSAG reviewed **DDIA**'s eligibility and enrollment data system, claims and encounter data processing system, provider data system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, **DDIA** demonstrated it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report accurate encounter data and performance measure rates to HHS. HSAG did not identify any concerns with **DDIA**'s data management and reporting processes. **DDIA** was able to report valid and reportable rates.

Table 4-10 displays measure designations and reportable measure rates for DWP Adults, Table 4-11 displays measure designations and reportable measure rates for DWP Kids, and Table 4-12 displays measure designations and reportable measure rates for the Hawki program. Specification changes made to Performance Measure 3, *Members Who Received Preventive Dental Care*, altered the measure's methodology and made the results between measurement years not directly comparable. Therefore, comparisons for this measure with Measurement Years 2023 and 2024 are not presented. **DDIA** received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 4-10—2023, 2024, and 2025 DDIA Performance Measure Designations and Rates for DWP Adults

Performance Measure		2023 Rate	2024 Rate	2025 Rate		
				Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	287,814	230,634	232,723	—	—
2	*Members Who Accessed Dental Care*	29.02%	28.90%	232,723	64,243	27.60%
3	*Members Who Received Preventive Dental Care*	NC	NC	64,243	61,037	95.01%

— A value is not applicable to the performance measure.
"NC" indicates rates are not comparable due to change in measurement specifications.

Table 4-11—2023, 2024, and 2025 Performance Measure Designations and Rates for Dental Wellness Plan Kids

Performance Measure		2023 Rate	2024 Rate	2025 Rate		
				Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	204,658	179,547	180,629	—	—
2	*Members Who Accessed Dental Care*	**	**	180,629	99,595	55.14%

Performance Measure		2023 Rate	2024 Rate	2025 Rate		
				Denominator	Numerator	Rate
3	*Members Who Received Preventive Dental Care*	NC	NC	99,595	97,444	97.84%

— A value is not applicable to the performance measure.
** The measure was not yet reported in the measurement year.
"NC" indicates rates are not comparable due to change in measurement specifications.

Table 4-12—2023, 2024, and 2025 Performance Measure Designations and Rates for Hawki Dental Plan

Performance Measure		2023 Rate	2024 Rate	2025 Rate		
				Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	53,976	64,353	69,570	—	—
2	*Members Who Accessed Dental Care*	**	**	69,570	45,073	64.79%
3	*Members Who Received Preventive Dental Care*	NC	NC	45,073	43,963	97.54%

— A value is not applicable to the performance measure.
** The measure was not yet reported in the measurement year.
"NC" indicates rates are not comparable due to change in measurement specifications.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: DDIA demonstrated improvement in data storage by transitioning to a cloud-based system monitored by its Information Security Department. This transition will enhance data accessibility and scalability while strengthening data protection and disaster recovery capabilities. [**Quality**]

Strength #2: DDIA demonstrated overall strong performance within its performance measure results, as its rates were highest in the State for all but one performance measure. [**Quality**]

Strength #3: DDIA demonstrated diligent internal oversight by proactively identifying and correcting source code issues without external prompting. [**Quality**]

Weaknesses and Recommendations

Weakness #1: During the PSV session of the virtual review, **DDIA** presented a member on screen whose information did not match the member listed in the member-level detail file. [**Quality**]

Why the weakness exists: **DDIA** discovered that the member listed in the member-level detail file did not belong in the specified measure but was a familial link to a member who was correctly reported in the measure

Recommendation: HSAG recommends **DDIA** add an extra step to its data validation quality assurance to ensure the correct members align with the specific measure. **DDIA** has also begun implementing an ongoing discrepancy report to identify any family members linked to Medicaid members for improved data accuracy as a result of the audit findings.

Compliance Review

Performance Results

Table 4-13 presents an overview of the results of the standards reviewed during the CY 2025 compliance review for **DDIA**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **DDIA** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 4-13—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	20	18	17	1	2	**94%**
Standard IX—Confidentiality	21	21	21	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	34	4	0	**89%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	6	6	6	0	0	**100%**
Standard XIII—Health Information Systems	9	9	8	1	0	**89%**
Standard XIV—Quality Assessment and Performance Improvement Program	12	12	11	1	0	**92%**
Total	**113**	**111**	**104**	**7**	**2**	**94%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: DDIA achieved full compliance for the Confidentiality program area, demonstrating that the PAHP had adequate processes in place to ensure compliance with the requirements stipulated in 45 CFR parts 160 and 164, subparts A and E. [**Quality**]

Strength #2: DDIA achieved full compliance for the Subcontractual Relationships and Delegation program area, demonstrating that the PAHP had policies and processes in place to provide sufficient oversight and monitoring of its delegated entities (e.g., delegated responsibilities, reporting requirements, and compliance with federal and State requirements). [**Quality**]

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

Weaknesses and Recommendations

Weakness #1: DDIA had four elements in the Grievances and Appeals program area that received a score of *Not Met*, indicating that the PAHP had not implemented a member grievance and appeal process in accordance with all federal and/or contractual requirements. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Through a review of written policies and procedures and case files, gaps in **DDIA**'s processes were identified related to timely acknowledgement of grievances, timely resolution of grievances, timely reinstatement of services, and the provision of information about the grievance and appeal system to all subcontractors at the time of contracting.

Recommendation: While **DDIA** was required to develop a CAP to address the identified deficiencies, HSAG recommends that the PAHP enhance oversight and monitoring of its grievance and appeal processes by conducting a comprehensive review of a random sample of grievance and appeal files and implementing corrective action for all identified deficiencies.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PAHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PAHP according to the CMS EQR Protocol 4 and as defined in Table A-11 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 4-14 presents a summary of the NAV validation ratings for **DDIA** by network adequacy standard type.

Table 4-14—Summary of DDIA Validation Ratings by Standard Type

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias	Could Not Be Validated
Time/Distance	100%	0%	0%	0%	0%
Appointment Wait Time	0%	0%	0%	0%	100%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of eight indicators for **DDIA**. All three Time/Distance indicators received a rating of *High Confidence* and the remaining five Appointment Wait Time indicators received a rating of *Could Not Be Validated*.

HSAG assessed results submitted by **DDIA** that included data reported as of December 31, 2024, representing a snapshot in time and summarizing cumulative network adequacy data collected over the preceding 12 months, and that indicated compliance with the network adequacy time and distance standards for dental providers. Table 4-15 summarizes these results. The compliance threshold for General Dentist is 100 percent. The compliance threshold for Specialty Dentist is 75 percent. Results that achieved the required percent threshold are shaded green and marked with a plus sign.

Table 4-15—DDIA Q2 Percentage of Members With Access Across Time and Distance Indicators

Provider Type	Indicator	Percentage of Members With Access
General Dentist	30 minutes or 30 miles from the Dental Wellness Plan (DWP) enrollee place of residence	100%+

Provider Type	Indicator	Percentage of Members With Access
Pediatric Dentist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	98.7%+
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	100%+
Periodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	57.0%
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	82.6%
Prosthodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	21.9%
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	40.5%
Oral Surgeon	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	91.0%+^
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	98.1%
Orthodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	94.3%+
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	100%+

Provider Type	Indicator	Percentage of Members With Access
Endodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	45.6%
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	65.1%

^Indicates compliance based on an HHS approved exception.

HSAG determined the appointment wait time standards in Table 4-16 required by HHS were not calculated and reported by **DDIA**, resulting in an "*Unable to Validate"* rating determination for each associated indicator

Table 4-16—DDIA Appointment Wait Time Indicators *Unable to Validate*

Provider Type	Indicators
Dentist	Not to exceed six to eight weeks for routine care
	Within 48 hours for persistent symptoms
	Within one day for urgent care
Specialty Care	Not to exceed 30 days for routine care
	Within one day for urgent care

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: DDIA maintained robust processes for verifying provider information quarterly by requiring providers to complete an online attestation before transactions such as claims submissions could occur. [**Quality**]

Strength #2: DDIA demonstrated exceptional commitment to operational resilience by cross-training multiple staff members on network adequacy reporting procedures which fostered comprehensive knowledge sharing across the team. [**Quality**]

Weaknesses and Recommendations

Weakness #1: DDIA collected average time to next appointment for reporting to HHS via the B11 report template; however, **DDIA** did not conduct an appointment wait time survey for internal monitoring and oversight that aligned with HHS' appointment wait time indicators. [**Quality** and **Access**]

Why the weakness exists: DDIA relied on the B11 template requirements for external reporting and did not fully integrate the State's appointment wait time standards into its internal monitoring protocols.

Recommendation: Although HHS did not require reporting of all appointment wait time indicators on the B11 template, the plans are required to conduct network adequacy monitoring and oversight of all network adequacy standards regardless of reporting required by the state. HSAG recommends that **DDIA** work with HHS to fully understand the appointment wait time standards and indicators and revise its survey protocols to include monitoring that aligns with these standards.

Weakness #2: The access for the provider types of Periodontist, Prosthodontist, and Endodontist was far below the established threshold for network adequacy compliance and were considered *Not Met*. The provider type Oral Surgeon was considered *Met* due to an HHS approved exception. This is due to factors such as a lack of available providers. [**Access**]

Why the weakness exists: As reported by the PAHP, persistent provider shortages in certain specialties and geographic areas limited **DDIA**'s ability to meet standard time/distance requirements.

Recommendation: HSAG recommends that **DDIA** continue to focus on solutions it has found to be effective in expanding its provider network, including utilizing general dentists who are licensed to provide specialist services.

Encounter Data Validation

Performance Results

HSAG conducted a series of comparative analyses divided into three analytic sections: Record Completeness, Data Element Completeness and Accuracy, and Overall Encounter Accuracy. Table 4-17 summarizes the key findings for **DDIA** based on an evaluation of whether dental encounters submitted by **DDIA** to HHS—and subsequently stored in HHS' data warehouse and extracted for submission to HSAG for the study—were accurate and complete when compared to the data submitted to HSAG by **DDIA**. The analysis targeted dental encounters with dates of service from July 1, 2023, through June 30, 2024, with a paid/adjudication date on or before November 30, 2024, and submitted to HHS on or before December 31, 2024.

Table 4-17—EDV Summary of Key Findings: DDIA

Analysis	Key Findings
Comparative Analysis	
Record Omission and Record Surplus	• Record omission and record surplus rates were both **0.2 percent**, indicating a high level of data completeness at the record level.
Data Element Completeness	• All data element omission and surplus rates were at or **below 1.1 percent**, indicating a high level of data completeness across nearly all evaluated data elements.
Data Element Accuracy	• Among evaluated key data elements, 11 out of 14 had element accuracy rates **greater than 99.0 percent**, indicating a high level of alignment between the two data sources. The only exceptions were the *Rendering Provider NPI* (**32.6 percent**), *Header Paid Amount* (**89.5 percent**), and *Detail Paid Amount* (**91.7 percent**) data elements.
All-Element Accuracy	• **DDIA** had a low all-element accuracy rate of **28.8 percent**, which was negatively affected by low accuracy rates for several key data elements.
Overall Encounter Accuracy	• In both comparison directions, **DDIA** had low exact match rates (**below 29.0 percent**), but high combined exact match and partial match rates (**greater than 99.0 percent**). The low match rates were driven by low element accuracy, which negatively affected the overall encounter match results.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses identified through the EDV were linked to and may affect, one or more of these domains. If a domain is not associated with an identified strength or weakness, the EDV findings did not indicate a significant impact on the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: The **DDIA**-submitted data exhibited high record-level data completeness, with low record omission and surplus rates. [**Quality**]

Strength #2: Among encounters that could be matched between the HHS-submitted data and the **DDIA**-submitted data, element-level completeness was high, demonstrated by low element omission and surplus rates across all evaluated key data elements. [**Quality**]

Weaknesses and Recommendations

Weakness #1: DDIA had low element accuracy rates for the *Rendering Provider NPI*, *Header Paid Amount*, and *Detail Paid Amount* fields. Consequently, these low element-level accuracy rates negatively affected both the all-element accuracy rate and the overall encounter accuracy rate. [**Quality**]

Why the weakness exists: Multiple errors in the data extraction process led to inaccurate values being populated in these fields (e.g., incorrect source fields used and reporting total paid amounts instead of plan-paid amounts).

Recommendation: HSAG recommends that **DDIA** strengthen its standard quality controls to ensure accurate data extraction in alignment with study requirements. These quality controls should include:

- Verifying that each data field is populated with the correct source field and reflects the appropriate business rules (e.g., plan-paid amounts only).
- Incorporating validation checks to confirm that fields (e.g., *Rendering Provider NPI*, *Header Paid Amount*, and *Detail Paid Amount*) are accurate and reasonable prior to submission.
- Develop and maintain data extraction procedures and documentation to promote consistency over time.

By implementing these procedures and controls, **DDIA** can reduce extract-related errors and improve both element-level and overall encounter accuracy in future submissions.

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

HSAG performed a comprehensive assessment of **DDIA**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **DDIA**'s overall performance contributed to the Iowa Managed Care Program's progress in achieving the Iowa HHS Medicaid Quality Strategy strategic priorities and objectives. Table 4-18 displays each strategic priority and the EQR activity results that indicate whether the PAHP positively (✓), negatively (✗), or minimally (●) impacted the Iowa Managed Care Program's progress toward achieving the applicable strategic priorities and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **DDIA**'s Medicaid and Hawki members. Additionally, not applicable (**NA**) was used if an Iowa HHS Medicaid Quality Strategy priority or related objective did not include any quality measures for **DDIA**'s programs or the EQR activities did not produce data to assess the impact under an Iowa HHS Medicaid Quality Strategy objective.

Table 4-18—Overall Performance Impact to Iowa HHS Medicaid Quality Strategy and Quality, Timeliness, and Access

Strategic Priority	Overall Performance Impact	Performance Domain
1.0 Access to Care	**Improve Behavioral Health Network Adequacy** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Improve Access to Maternal Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Improve Access to LTSS Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Improve Access to Primary Care and Specialty Care** ✓ For the *Annual Preventative Dental Visits* PIP in CY 2025, **DDIA** demonstrated statistically significant improvement over the baseline measurement period for Remeasurement 3 for the DWP Kids performance indicator. ✗ **DDIA** demonstrated a statistically significant decline over the baseline measurement period for the Remeasurement 3 for the DWP Adults performance indicator.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year. ✓ Through the PMV activity, **DDIA** achieved a rate of 95.01 percent for DWP Adults for the *Members Who Received Preventive Dental Care* performance measure, indicating a positive impact on the Iowa HHS Medicaid Quality Strategy objective to *Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year*. ✓ Through the PMV activity, **DDIA** achieved a rate of 97.84 percent for the DWP Kids for the *Members Who Received Preventive Dental Care* performance measure, indicating a positive impact on the Iowa HHS Medicaid Quality Strategy objective to *Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year*. ✓ Through the PMV activity, **DDIA** achieved a rate of 97.54 percent for Hawki for the *Members Who Received Preventive Dental Care* performance measure, indicating a positive impact on the Iowa HHS Medicaid Quality Strategy objective to *Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year*. ✗ Through the PMV activity, **DDIA** achieved a rate of 27.60 percent for the DWP Adults for the *Members Who Accessed Dental Care* performance measure, indicating a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year*. NA The NAV EQR activities did not produce data to assess the impact for of provider-to-member ratios for this objective. However, the Iowa HHS Medicaid Quality Strategy indicated that HHS would update the network adequacy standards to include minimum required provider-to-member ratios for dentists. As such, performance of these measures will be assessed in future technical reports when included as part of the NAV and compliance activities.	

Strategic Priority	Overall Performance Impact	Performance Domain
2.0 Whole Person Coordinated Care	**Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Improve Prenatal and Postpartum Comprehensive Care Management** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective.	☒ Quality ☒ Timeliness ☒ Access
3.0 Health Equity	**Address Disparities in Behavioral Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Address Disparities in Maternal Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Address Disparities in LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Primary and Specialty Care Services** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☒ Timeliness ☒ Access
4.0 Program Administration	**Grievances, Appeals, and Exception to Policy** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access

Strategic Priority	Overall Performance Impact	Performance Domain
5.0 Voice of the Customer	NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective.	☒ Quality ☐ Timeliness ☐ Access

Managed Care of North America Dental

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **MCNA**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence,* or *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence,* or *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 4-19 displays the validation ratings and performance indicators.

Table 4-19—Overall Validation Rating for MCNA

PIP Topic	Validation Rating 1*	Validation Rating 2*	Performance Indicators	Performance Indicator Results			
				Baseline	R1	R2	R3
Increase the Percentage of Dental Services	*High Confidence*	*High Confidence*	1. The percentage of members 19 years of age and older who had at least one preventive dental visit during the measurement year.	61.70%	60.19% ↓	61.13% ⇔	62.61% ↑
			2. The percentage of members 18 years of age and younger who had at least one preventive dental visit during the measurement year.	35.86%	37.88% ↑	42.28% ↑	42.18% ↑

Validation Rating 1 = Overall confidence of adherence to acceptable methodology for all phases of the PIP.
Validation Rating 2 = Overall confidence that the PIP achieved significant improvement.
R1 = Remeasurement 1
R2 = Remeasurement 2
R3 = Remeasurement 3
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* Based on the scores assigned for individual evaluation elements in the PIP Validation Tool and the confidence level definitions provided in Appendix A.

The goal for **MCNA**'s PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Table 4-20 displays barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the PAHP to support achievement of the PIP goals and address the barriers.

Table 4-20—Remeasurement 2 Barriers and Interventions for MCNA

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MCNA conducted accurate statistical testing between the baseline and third remeasurement period and provided a narrative interpretation of the comparison. The PAHP used appropriate quality improvement tools to conduct its causal/barrier analysis. [**Quality**]

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

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses.

Why the weakness exists: NA

Recommendation: Although no weaknesses were identified, HSAG recommends that **MCNA** continue to evaluate the effectiveness of each intervention and use lessons learned to spread the intervention to improve other areas of care as appropriate.

Performance Measure Validation

Performance Results

HSAG reviewed **MCNA**'s eligibility and enrollment data system, claims and encounter data processing system, provider data system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, **MCNA** demonstrated it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report accurate encounter data and performance measure rates to HHS. HSAG did not identify any concerns with **MCNA**'s processes. **MCNA** was able to report valid and reportable rates.

Table 4-21 displays measure designation and reportable measure rates for DWP Adults and Table 4-22 displays designation and reportable measure rates for DWP Kids. Specification changes made to Performance Measure 3, *Members Who Received Preventive Dental Care*, altered the measure's methodology and made the results between measurement years not directly comparable. Therefore, comparisons for this measure with Measurement Years 2023 and 2024 are not presented. **MCNA** received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 4-21—2023, 2024, and 2025 Performance Measure Designations and Rates for Dental Wellness Plan

Performance Measure		2023 Rate	2024 Rate	2025 Rate		
				Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	174,100	136,683	125,614	—	—
2	*Members Who Accessed Dental Care*	16.00%	16.50%	125,614	23,028	18.33%
3	*Members Who Received Preventive Dental Care*	NC	NC	23,028	21,814	94.73%

— A value is not applicable to the performance measure.
"NC" indicates rates are not comparable due to change in measurement specifications.

Table 4-22—2023, 2024, and 2025 Performance Measure Designations and Rates for Dental Wellness Plan Kids

Performance Measure		2023 Rate	2024 Rate	2025 Rate		
				Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	125,471	102,435	95,383	—	—
2	*Members Who Accessed Dental Care*	**	**	95,383	43,447	45.55%
3	*Members Who Received Preventive Dental Care*	NC	NC	43,447	42,912	98.77%

— A value is not applicable to the performance measure.
** The measure was not yet published in the measurement year.
"NC" indicates rates are not comparable due to change in measurement specifications.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MCNA demonstrated strength through its two value-based incentive programs: one promoting timely recall visits and another supporting members in establishing a dental home and completing comprehensive dental or periodontal exams. These initiatives enhance both quality and continuity of care. [**Quality**]

Weaknesses and Recommendations

Weakness #1: While HSAG's PMV did not identify any concerns or weaknesses with **MCNA**'s information systems, data accuracy, and completeness or performance measure calculation, **MCNA**'s rates were more than 9 percentage points lower than the other Iowa PAHP, for both *DWP Kids* and *DWP Adults members with at least six months of continuous enrollment in the PAHP who had at least one dental service during the six or more months of continuous enrollment during the measurement year.* [**Quality** and **Access**]

Why the weakness exists: Based solely on performance measure rates, it appears that **MCNA**'s DWP Kids and DWP Adults members did not access dental services as frequently as DWP Kids and DWP Adults members accessed dental services when compared to the other Iowa PAHP's performance measure results. Although data completeness was not identified as a gap for **MCNA**, lower rates may be indicative of an unexpected claims lag or an opportunity to access other data sources (e.g., supplemental data).

Recommendation: Although **MCNA** will no longer serve Iowa DWP Kids and Iowa DWP Adults members after June 30, 2026, HSAG recommends **MCNA** prioritize ensuring its DWP Kids and DWP Adults members who have not yet accessed dental services, do so prior to June 30, 2026. **MCNA** may accomplish this by leveraging existing initiatives (i.e., value-based incentive programs) or by deploying targeted outreach campaigns to assist individual members with appointment reminders and scheduling options. Additionally, **MCNA** should consider evaluating whether its claims lag has historically extended beyond its expected time frame or whether other data sources are available to provide additional utilization details to support the performance measures.

Compliance Review

Performance Results

Table 4-23 presents an overview of the results of the standards reviewed during the CY 2025 compliance review for **MCNA**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **MCNA** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 4-23—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	20	18	17	1	2	**94%**
Standard IX—Confidentiality	21	21	20	1	0	**95%**
Standard X—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard XI—Subcontractual Relationships and Delegation	7	7	6	1	0	**86%**
Standard XII—Practice Guidelines	6	6	6	0	0	**100%**
Standard XIII—Health Information Systems	9	9	7	2	0	**78%**
Standard XIV—Quality Assessment and Performance Improvement Program	12	12	10	2	0	**83%**
Total	**113**	**111**	**98**	**13**	**2**	**88%**

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

Weakness #1: MCNA had six elements in the Grievances and Appeals program area that received a score of *Not Met*, indicating that the PAHP had not implemented a member grievance and appeal process in accordance with all federal and/or contractual requirements. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Through a review of written policies and procedures and case files, gaps in **MCNA**'s processes were identified related to timely acknowledgement of grievances and appeals, timely resolution of grievances, providing members their full filing time frame for an appeal, the content of post-service appeal resolution letters (including the time frame to request a State fair hearing), and the provision of information to members of their right to file a grievance when they disagreed with a resolution time frame extension.

Recommendation: While **MCNA** was required to develop a CAP to address the identified deficiencies, HSAG recommends that the PAHP enhance oversight and monitoring of its grievance and appeal processes by conducting a comprehensive review of a random sample of grievance and appeal files and implementing corrective action for all identified deficiencies.

Weakness #2: MCNA had two elements in the Health Information Systems program area that received a score of *Not Met*, indicating that the PAHP was not in full compliance with all federal and contractual requirements. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: MCNA did not implement the API requirements, specifically, the patient access API and provider directory API. While the PAHP indicated it has project plans in place to implement the required APIs, the API requirements for implementation have been effective since 2021.

Recommendation: While **MCNA** was required to develop a CAP to address the identified deficiencies, HSAG strongly recommends that the PAHP timely implement the required APIs to be compliant with the federal rule and its contract with the State. HSAG also recommends that **MCNA** educate its staff on Medicaid program requirements and the importance of distinguishing between varying requirements across different lines of business.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the PAHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each PAHP according to the CMS EQR Protocol 4 and as defined in Table A-11 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 4-24 presents a summary of the NAV validation ratings for **MCNA** by network adequacy standard type.

Table 4-24—Summary of MCNA Validation Ratings by Standard Type

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias	Could Not Be Validated
Time/Distance	100%	0%	0%	0%	0%
Appointment Wait Time	80%	0%	0%	0%	20%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of eight indicators for **MCNA**. All three Time/Distance indicators received a rating of *High Confidence,* four Appointment Wait Time indicators received a rating of *High Confidence,* and the one remaining Appointment Wait Time indicator received a rating of *Could Not Be Validated*.

HSAG assessed results submitted by **MCNA** that included data reported as of December 31, 2024, representing a snapshot in time and summarizing cumulative network adequacy data collected over the preceding 12 months, and that indicated compliance with the network adequacy time and distance standards for dental providers. Table 4-25 summarizes these results. The compliance threshold for General Dentist is 100 percent. The compliance threshold for Specialty Dentist is 75 percent. Results that achieved the required percent threshold are shaded green and marked with a plus sign.

Table 4-25—MCNA Q2 Percentage of Members With Access Across Time and Distance Indicators

Provider Type	Indicator	Percentage of Members With Access
General Dentist	30 minutes or 30 miles from the Dental Wellness Plan (DWP) enrollee place of residence	98.5%

Provider Type	Indicator	Percentage of Members With Access
Pediatric Dentist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	99.1%+
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	100%+
Periodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	40.1%
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	72.7%
Prosthodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	33.7%
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	61.0%
Oral Surgeon	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	86.7%+^
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	100%+^
Orthodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	94.1%+
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	100%+

Provider Type	Indicator	Percentage of Members With Access
Endodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	40.4%
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	62.9%

^Indicates compliance based on an HHS approved exception.

HSAG assessed the appointment wait time indicator results submitted by **MCNA** and evaluated compliance across two provider types. Results were determined based on reviews of **MCNA** reporting standards that directly corresponded to HHS' standards and indicators. Table 4-26 summarizes **MCNA** appointment wait time survey results of provider compliance across HHS-defined appointment wait time indicators. HSAG identified one indicator that was not reported, resulting in an "*Unable to Validate*" rating determination for that indicator.

Table 4-26—MCNA Provider Network Percent Compliance for Appointment Wait Time Indicators

Provider Type	Indicator	Percent Within Standard
Dentist	Not to exceed six to eight weeks for routine care	69.88%
	Within 48 hours for persistent symptoms	79.74%
	Within one day for urgent care	80.61%
Specialty Care	Within one day for urgent care	80.61%
Specialty Care	Not to exceed 30 days for routine care	Unable to Validate

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: MCNA proactively reached out to specialist providers in neighboring states to increase access to specialty dental care for members. Additionally, **MCNA** worked with general dentists with

expanded scope of practice to provide specialty services to members in rural areas without access to specialists. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: MCNA excluded between 5 percent and 6 percent of members from reporting due to an inability to geocode these members. [**Quality**]

Why the weakness exists: HHS did not provide guidance to **MCNA** on how to handle such members.

Recommendation: HSAG recommends that **MCNA** work with HHS to understand how to consider members who cannot be geocoded in reporting.

Weakness #2: MCNA did not ask specialist dentists if appointments were available within 30 days as required by HHS as part of their provider surveys. [**Quality**]

Why the weakness exists: MCNA did not complete a separate appointment wait time survey that was inclusive of all contractual appointment wait time standards.

Recommendation: HSAG recommends that **MCNA** updates its appointment wait time provider survey to ensure alignment with requirements from HHS, including the validation of 30-day appointment availability with all specialist providers.

Weakness #3: The access for the provider types of Periodontist, Prosthodontist, and Endodontist was far below the established threshold for network adequacy compliance and were considered *Not Met*. The provider type Oral Surgeon was considered *Met* due to an HHS approved exception. This is due to factors such as a lack of available providers. [**Access**]

Why the weakness exists: As reported by the PAHP, persistent provider shortages in certain specialties and geographic areas limited **MCNA**'s ability to meet standard time/distance requirements.

Recommendation: HSAG recommends that **MCNA** continue to focus on solutions it has found to be effective in expanding its provider network, including expanding contracting with specialist providers in neighboring states.

Encounter Data Validation

Performance Results

HSAG conducted a series of comparative analyses divided into three analytic sections: Record Completeness, Data Element Completeness and Accuracy, and Overall Encounter Accuracy. Table 4-27 summarizes the key findings for **MCNA** based on an evaluation of whether dental encounters submitted by **MCNA** to HHS—and subsequently stored in HHS' data warehouse and extracted for submission to HSAG for the study—were accurate and complete when compared to the data files submitted to HSAG by **MCNA**. The analysis targeted dental encounters with dates of service from July 1, 2023, through June 30, 2024, a paid/adjudication date on or before November 30, 2024, and submitted to HHS on or before December 31, 2024.

Table 4-27—EDV Summary of Key Findings: MCNA

Analysis	Key Findings
Comparative Analysis	
Record Omission and Record Surplus	• Record omission and record surplus rates were both less than **4.0 percent**, indicating a high level of data completeness at the record level.
Data Element Completeness	• All data element omission and surplus rates were **below 1.0 percent**, indicating a high level of data completeness across nearly all evaluated key data elements.
Data Element Accuracy	• Among evaluated key data elements, 11 out of 14 had element accuracy rates **greater than 95.0 percent**, indicating a high level of alignment between the two data sources. The exceptions were the *Current Dental Terminology* (*CDT*) *Code* (**94.6 percent**), *Tooth Number* (**94.5 percent**), and *Header Paid Amount* (**10.4 percent**) data elements.
All-Element Accuracy	• **MCNA** had a very low all-element accuracy rate of **9.8 percent**, which was negatively affected by low accuracy rates of several key data elements.
Overall Encounter Accuracy	• In both comparison directions, **MCNA** had very low exact match rates (**below 11.0 percent**), but high combined exact match and partial match rates (**greater than 99.0 percent**). The low match rates were driven by low element-level accuracy, which negatively affected the overall encounter results.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses identified through the EDV were linked to and may affect, one or more of these domains. If a domain is not associated with an identified strength or weakness, the EDV findings did not indicate significant impact on the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: The **MCNA**-submitted data exhibited high record-level data completeness, with low record omission and surplus rates. [**Quality**]

Strength #2: Among encounters that could be matched between the HHS-submitted data and the **MCNA**-submitted data, element-level completeness was high, demonstrated by low element omission and surplus rates across all evaluated key data elements. [**Quality**]

Weaknesses and Recommendations

Weakness #1: MCNA had a low element accuracy rate for the *Header Paid Amount* field. Consequently, this low element-level accuracy rate negatively affected both the all-element accuracy rate and the overall encounter accuracy rate. [**Quality**]
Why the weakness exists: MCNA stated that it erroneously populated the *Header Paid Amount* field with the *Detail Paid Amount* field values.
Recommendation: HSAG recommends that **MCNA** strengthen its standard quality controls to ensure accurate data extraction in alignment with study requirements. Specifically, **MCNA** should:

- Verify that the *Header Paid Amount* and *Detail Paid Amount* data elements are populated from the correct source fields and reflect the appropriate payment logic.
- Implement validation checks to confirm that header- and detail-level paid amounts are reasonable, distinct where appropriate, and aligned with program rules.
- Develop and maintain data extraction procedures and documentation to promote consistency over time.

By implementing these measures, **MCNA** can reduce extract-related errors and improve both element-level and overall encounter accuracy in future submissions.

Weakness #2: MCNA had low element accuracy rates for the *CDT Code* and *Tooth Number* fields. Consequently, these low element-level accuracy rates negatively affected both the all-element accuracy rate and the overall encounter accuracy rate. [**Quality**]
Why the weakness exists: MCNA reported that misalignment of detail lines for these data elements occurred because the data extract was ordered by *internal control number* (*ICN)* only, rather than by both *ICN* and *managed care entity identification* (*MCE ID)*.
Recommendation: HSAG recommends that **MCNA** strengthen its quality controls to ensure accurate data extraction in alignment with study requirements. Specifically, **MCNA** should:

- Review and revise its sorting and grouping logic to ensure proper alignment of header and detail lines.
- Develop and maintain standardized, documented data extraction procedures that clearly define key fields, sort order, and grouping logic for all encounter types.
- Implement validation checks (such as spot-checking *CDT Code* and *Tooth Number* values across a sample of encounters) to detect and correct misalignment issues prior to submission.

By implementing these measures, **MCNA** can reduce extract-related errors and improve both element-level and overall encounter accuracy in future submissions.

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

HSAG performed a comprehensive assessment of **MCNA**'s aggregated performance, and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **MCNA**'s overall performance contributed to the Iowa Managed Care Program's progress in achieving the Iowa HHS Medicaid Quality Strategy strategic priorities and objectives. Table 4-28 displays each strategic priority and the EQR activity results that indicate whether the PAHP positively (✓), negatively (✗), or minimally (●) impacted the Iowa Managed Care Program's progress toward achieving the applicable strategic priorities and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **MCNA**'s Medicaid members. Additionally, not applicable (**NA**) was used if an Iowa HHS Medicaid Quality Strategy priority or related objective did not include any quality measures for **MCNA**'s programs or the EQR activities did not produce data to assess the impact under an Iowa HHS Medicaid Quality Strategy objective.

Table 4-28—Overall Performance Impact to Iowa HHS Medicaid Quality Strategy and Quality, Timeliness, and Access

Strategic Priority	Overall Performance Impact	Performance Domain
1.0 Access to Care	**Improve Behavioral Health Network Adequacy** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP for this service. **Improve Access to Maternal Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP for this service. **Improve Access to LTSS Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP for this service. **Improve Access to Primary Care and Specialty Care** ✓ For the *Increase the Percentage of Dental Services* PIP in CY 2025, **MCNA** demonstrated statistically significant improvement over the baseline measurement period for Remeasurement 3 for the percentage of members 19 years of age and older and the percentage of members 18 years of age and younger performance indicators. **Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year.** ✓ Through the PMV activity in CY 2025, **MCNA** achieved 94.73 percent for the *Members Who*	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Received Preventive Dental Care performance measure for DWP Adults and 98.77 percent for the *Members Who Received Preventive Dental Care* performance measure for DWP Kids, indicating a positive impact on the Iowa HHS Medicaid Quality Strategy objective to *Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year*. ✗ Through the PMV activity, **MCNA** achieved a rate of 18.33 percent for the *Members Who Accessed Dental Care* performance measure for DWP Adults, indicating a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year*. NA The NAV EQR activities did not produce data to assess the impact of provider-to-member ratios for this objective. However, the Iowa HHS Medicaid Quality Strategy indicated that HHS would update the network adequacy standards to include minimum required provider-to-member ratios for dentists. As such, performance of these measures will be assessed in future technical reports when included as part of the NAV and compliance activities.	
2.0 Whole Person Coordinated Care	**Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP. **Improve Prenatal and Postpartum Comprehensive Care Management** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP. **Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
3.0 Health Equity	**Address Disparities in Behavioral Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP. **Address Disparities in Maternal Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP. **Address Disparities in LTSS Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP. **Address Disparities in Primary and Specialty Care Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP.	☒ Quality ☒ Timeliness ☒ Access
4.0 Program Administration	**Grievances, Appeals, and Exception to Policy** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access
5.0 Voice of the Customer	NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the CY 2025 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Iowa Managed Care Program. The recommendations provided to each MCO for the EQR activities in the *Calendar Year 2024 External Quality Review Technical Report* are summarized in this section. The MCO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided.

Iowa Total Care, Inc.

Validation of Performance Improvement Projects

Prior Year Recommendations from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • HSAG did not identify any weaknesses through the PIP activity. HSAG recommends **ITC** ensure that it follows the approved PIP methodology to calculate and report the baseline data accurately in the next annual submission.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Iowa Total Care appreciates HSAG's thorough review and are pleased that no weaknesses were identified in the Performance Improvement Project (PIP) activity. We acknowledge the recommendation to ensure adherence to the approved PIP methodology, particularly in the accurate calculation and reporting of baseline data. ITC is committed to continuous improvement and will take the necessary steps to align with the methodology in preparation for the next annual submission.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Assessment: HSAG determined that **ITC** addressed the prior year's recommendation. The MCO followed the approved PIP methodology to calculate and report the baseline data accurately.

Performance Measures

Prior Year Recommendations From the EQR Technical Report for Performance Measures
HSAG recommended the following: • **ITC**'s performance in the Access to Preventive Care Domain remained low for the *Use of Imaging Studies for Low Back Pain* measure, which ranked below the 25th percentile. HSAG recommends that **ITC** ensure providers are aware of best practices regarding imaging studies for low back pain, including avoiding diagnostic imaging in the first four weeks of new-onset back pain, unless red flags or other conditions are present, and encouraging management of back pain through regular physical activity, healthy back exercises, and education on injury prevention. HSAG recommends that **ITC** consider using quality interventions that have been shown to improve appropriate imaging studies for low back pain, including increased provider oversight, providers getting education about HEDIS specifications, specific imaging prompts in the EMR, and quality scorecards for providers. • **ITC**'s performance in the Behavioral Health domain continued to rank below the 25th percentile for the Metabolic Monitoring for *Children and Adolescents on Antipsychotics—Diabetes Monitoring for Blood Glucose and Cholesterol Testing—Total*. Addressing the physical health needs of members diagnosed with mental health conditions is an important way to improve overall health, quality of life, and economic outcomes. Additionally, monitoring of blood glucose and cholesterol testing are important components of ensuring appropriate management of children and adolescents on antipsychotic medications. HSAG recommends **ITC** assess how providers are coordinating on antipsychotic care. In one study, members who saw a PCP and mental health provider over the year had a higher rate of receiving metabolic monitoring. Therefore, encouraging joint monitoring might increase the rate of metabolic monitoring. Further, HSAG recommends **ITC** generate provider data reports to identify trends in whether providers are prescribing antipsychotics and not doing metabolic monitoring. • During source code review and PSV, HSAG identified multiple areas of specification misalignment, specifically pertaining to continuous enrollment criteria and length of stay calculations. HSAG recommends that **ITC** implement a multi-layer peer review approach to source code and data output review and approval, using peer review processes at the analyst and management level to ensure full application and alignment of the specifications. HSAG also recommends that **ITC** conduct ongoing internal PSV on a subset of cases each month for assurance in specification alignment and rate calculations.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • In alignment with HSAG's recommendations to improve performance on the Use of Imaging Studies for Low Back Pain measure, ITC implemented a series of targeted interventions focused on provider education, clinical guideline adherence, and diagnostic accuracy. Key initiatives included: o **Provider Identification and Education:** ITC identified ordering providers, including chiropractors and orthopedic specialists, whose imaging practices were outside of Clinical Practice Guidelines (CPGs). These providers received targeted education on both the CPGs and HEDIS measure specifications. o **Diagnosis Code Accuracy:** Providers were instructed to update diagnosis codes to reflect the most specific and clinically appropriate reasons for imaging, ensuring alignment with HEDIS criteria.

Prior Year Recommendations From the EQR Technical Report for Performance Measures
○ **Promotion of Conservative Treatment:** Reinforcement of the "try and fail" approach to conservative treatment was emphasized, consistent with CPGs, prior to ordering imaging. ○ **Professional Outreach:** A formal presentation was delivered at the 2024 Chiropractors Association meeting by Quality Practice Advisors (QPAs), highlighting best practices and compliance expectations. ○ **Ongoing Quality Engagement:** QPAs continue to provide individualized education to primary care providers (PCPs) who demonstrate non-compliance, focusing on accurate diagnosis documentation and evidence of conservative treatment efforts • To address low performance in the Behavioral Health domain, specifically for metabolic monitoring among children and adolescents prescribed antipsychotics, ITC implemented a multi-pronged strategy focused on education, outreach, and care coordination. Key initiatives included: ○ **Provider and Member Education:** ITC increased awareness among both providers and members regarding the importance of annual blood glucose and cholesterol testing for youth on antipsychotic medications. ○ **Behavioral Health Provider Incentives:** Incentives were introduced to encourage behavioral health providers to prioritize metabolic monitoring as part of comprehensive care. ○ **Member Engagement via Text Messaging:** Members received targeted text reminders to complete annual metabolic testing, improving outreach and compliance. ○ **Pharmacy Outreach:** Letters were sent to members newly identified in the measure, as well as to PCPs and behavioral health providers, emphasizing the need for testing and coordinated care. ○ **Direct Support for Non-Compliant Members:** In April 2025, ITC distributed test kits to non-compliant members aged 12 and older to reduce barriers to completing required screenings. • In response to HSAG's findings related to specification misalignment, specifically pertaining to continuous enrollment criteria and length of stay calculations, ITC has in place a review policy whenever changes are made to the code for the MLTSS calculations: ○ An analyst peer will review the revised code to ensure adherence to measurement specifications. ○ The manager of the analysts doing the primary code modification will also review the revised code to ensure adherence to measurement specifications. • Further, LTSS subject matter experts will review a subset of cases with each report to verify that the length of stay and other calculations in the report align with their records for those members.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As it relates to the Use of Imaging Studies for Low Back Pain measure - there was no improvement based on the interventions completed in 2024. • As it relates to the Metabolic monitoring among children and adolescents prescribed antipsychotics (APM) measure - ITC did not improve Year over Year. APM switched to an ECDS measure for MY2024. Iowa Total Care's final rate for APM in MY2024 was 26.70%, which reflects an overall improvement from 20.76% in MY2020. While there was a slight decline of -1.11 percentage points from MY2023 to MY2024, the long-term trend shows consistent gains in performance. • Related to the LTSS Length of Stay Calculation, there have been no instances of measure calculations that did not adhere to the specifications.

Prior Year Recommendations From the EQR Technical Report for Performance Measures
c. Identify any barriers to implementing initiatives: • As it relates to the Use of Imaging Studies for Low Back Pain measure, an ITC barrier has noted is that Chiropractors and Orthopedic Surgeons do not see these measures as a focus area. • As it relates to the Metabolic monitoring among children and adolescents prescribed antipsychotics (APM) measure, the following barriers were identified: o Care Coordination Challenges**:** Disconnect between prescribing behavioral health providers and PCPs responsible for lab testing. o Lack of Education and Awareness: Providers and members unaware of the need for metabolic monitoring. Providers only ordering Glucose and not Cholesterol o Member Limitations: Mental and physical health challenges limited ability to complete lab tests. To alleviate this, Iowa Total Care implemented home testing kits for members to attempt lab draw in own home to reduce barrier.
HSAG Assessment: HSAG has determined that **ITC** addressed the prior year's recommendations based on the MCO's reported initiatives. Although **ITC** developed improvement strategies based on the prior year's recommendations (i.e., interventions) that are designed to target the population(s) and age group(s) to successfully improve member outcomes, there is additional room for improvement with measures that declined in performance or did not meet the national benchmarks.

Compliance Review

Prior Year Recommendations From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **ITC** had three elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. While **ITC** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary. • **ITC** had three elements in the Coordination and Continuity of Care program area that received a score of *Not Met*, indicating members' care may not be effectively coordinated through the care management program. While **ITC** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members. • **ITC** had three elements in the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of authorization decisions, including decisions that result in an ABD to the member, and that **ITC** did not meet all UM requirements outlined in its Contract with HHS. While **ITC** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and

Prior Year Recommendations From the EQR Technical Report for Compliance Review
authorization of services. Further, HSAG recommends that the MCO begin preparations to implement the new seven calendar day authorization time frame, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • As it relates to the Member Rights and Member Information program area, recommendations were made regarding Member Rights and Member Information. HSAG recommended for the MCO to expand the information pertaining to availability of service, assurances of adequate capacity and services, coordination and continuity of care and coverage and authorization of services. ITC developed a tool to support annual review of the Member Handbook and ensure core information included aligns with ITC's processes and practices. These tools will be used as ITC works through review of the Member Handbook in 2025. Additionally, throughout the year, as member materials are developed, the Marketing Team solicits information on whether the changes being made require updates to the Member Handbook and/or Provider Manual. This ongoing review process supports a comprehensive annual update and ensures consistency across member communications. • Regarding Coordination and Continuity of Care and Coverage and Authorization of Services program area, ITC's Medical Management Committee is a standing subcommittee of the Quality Management Quality Improvement (QM/QI) Committee. The Medical Management Committee has oversight of the policies and outcomes related to ITC's coverage authorization processes. Both the Medical Management Committee and QM/QI Committees help ensure ITC continually improves established processes to ensure member access to care and compliance with all state and federal rules. These committees meet on a quarterly basis, or ad hoc, as needed. In addition, members, participating providers, and community-based organizations can participate in the ITC's Stakeholder Advisory Board and the LTSS Advisory Committee to offer feedback and recommendations about ITC's processes and policies. Both Advisory Boards report out to the QM/QI Committee. • Utilization Management teams and UM vendor team implemented process and system updates on 10/1/24 to move towards implementing the seven-calendar day authorization time frame. Iowa Total Care leadership monitors the seven-calendar day turn-around-time (TAT) report on, at least, a monthly basis and since the implementation it has been going well. Iowa Total has initiated steps to have information updated to include the change to the seven-calendar day turnaround time in Utilization Management and vendor policies, procedures and authorization request forms.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Regarding Member Rights and Member Information, there have been no identified performance improvements. However, ITC's tools and processes will be leveraged during the next review cycle for the Member Handbook and Provider Manual. • Regarding Authorization and Coverage of Services and Coordination and Continuity of Care, ITC's performance improvements are documented as part of the annual evaluations and reports submitted to HHS. • As it relates to Coverage and Authorization of Services, since implementing the 7 day TAT, Iowa Total Care is consistently meeting TAT metrics.

Prior Year Recommendations From the EQR Technical Report for Compliance Review
c. Identify any barriers to implementing initiatives: • ITC has not identified any barriers, at this time.
HSAG Assessment: HSAG has determined that **ITC** addressed the prior year's recommendations based on the MCO's reported initiatives for the Coverage and Authorization of Services program area. The MCO's response addressed the gaps noted regarding adherence to the requirements related to the timing of authorization decisions. HSAG has also determined that **ITC** addressed the prior year's recommendations based on the MCO's reported initiatives for the Member Rights and Member Information program area. The MCO's response addressed the gaps noted regarding adherence to State and federal requirements. Further, HSAG has determined that **ITC** partially addressed the prior year's recommendations based on the MCO's reported initiatives for the Coordination and Continuity of Care program area. While the MCO stated its committees have oversight of its policies and processes, HSAG recommends that the MCO also ensure staff clearly document any non-LTSS member communication plans; prioritized goals and defined outcomes for non-LTSS case-managed members; and face-to-face check-in schedules to monitor members' progress.

Network Adequacy Validation

Prior Year Recommendations From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **ITC** did not utilize HHS' standards and indicators for appointment wait times when conducting provider surveys. HSAG recommends that **ITC** work with HHS to fully understand the appointment wait time standards and indicators and revise its survey protocol to accurately measure compliance with State standards.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Iowa Total Care Operational Leaders engaged a workgroup to review performance and improvement opportunities as well as state specific appointment wait time standards and indicators. Additionally, a joint Operational MCO meeting is scheduled on 10/20/25 in which the MCO Operation Leaders will be discussing differences in current standards being used. Following that meeting, for alignment purposes, the MCOs will work jointly with HHS, provide recommendations and determine changes needed to accurately measure compliance with State standards.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Expected alignment between State standards and MCO measures used and reported for appointment wait times.
c. Identify any barriers to implementing initiatives: • None identified at this time.

Prior Year Recommendations From the EQR Technical Report for Network Adequacy Validation
HSAG Assessment: HSAG has determined that ITC partially addressed the prior year's recommendations. Although ITC leadership engaged in review, coordinated with other MCOs to schedule a discussion regarding the standards, and indicated planned follow-up with HHS after the joint MCO meeting, ITC did not report any initial outreach and coordination with HHS to ensure compliance with HHS standards when completing appointment wait time surveys in CY 2025.

Encounter Data Validation

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • For institutional encounters, ITC had low element accuracy rates (below 95.0 percent) for *Secondary Diagnosis Code(s)*, *Secondary Surgical Procedure Code(s)*, and *Drug Code* data elements. HSAG recommends that ITC collaborate with HHS to clarify and align encounter submission standards for the affected data elements, ensuring consistency in coding, deduplication, and data aggregation practices. Additionally, ITC should implement standardized quality control measures to identify and correct discrepancies before submission, particularly for secondary diagnosis codes, surgical procedure codes, and drug codes. Lastly, ITC should review and refine its data extraction processes to ensure reported values are formatted and aggregated in alignment with HHS's expectations. These actions will help improve data accuracy and consistency in future submissions.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • ITC has updated the coding logic in our data extraction process to ensure the inclusion of secondary diagnosis codes, secondary procedure codes, and Drug Codes. This enhancement aligns our data submissions with HHS encounter submission standards, improving both compliance and data completeness. To maintain data integrity, we've implemented a multi-step quality control process that proactively identifies potential issues related to: o Secondary diagnosis codes o Secondary surgical procedure codes o Drug codes • This process helps ensure accuracy and consistency across all extracted data sets.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • ITC has successfully tested the modified coding logic, confirming that the inclusion of secondary diagnosis codes, secondary surgical procedure codes, and Drug Codes meets HHS encounter submission standards. This validation reinforces our commitment to compliance and data accuracy, ensuring that all required elements are properly captured and submitted.

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
c. Identify any barriers to implementing initiatives: • ITC did not encounter any barriers during the implementation of these initiatives, allowing for a smooth transition and timely validation.
HSAG Assessment: HSAG has determined that **ITC** fully addressed the recommendations. **ITC** described concrete and completed actions that directly align with HSAG's guidance, including updating coding logic within its data extraction process to ensure the accurate inclusion of secondary diagnosis codes, secondary surgical procedure codes, and drug codes. These updates address the previously identified issues related to low element accuracy and demonstrate appropriate alignment with HHS' encounter submission standards. In addition, **ITC** implemented a standardized, multi-step quality control process specifically designed to identify and correct discrepancies related to the affected data elements prior to submission. **ITC** also reported successful testing and validation of the revised coding logic, confirming that reported values now meet HHS' expectations for completeness, formatting, and aggregation. This testing provides reasonable assurance that the implemented changes are functioning as intended and are likely to result in improved data accuracy in future submissions. **ITC** reported no barriers to implementing these initiatives, indicating that the corrective actions were incorporated smoothly and in a timely manner. To further strengthen its approach, HSAG recommends that **ITC** continue routine monitoring of these data elements through ongoing quality checks and periodically revalidate extraction logic as submission requirements evolve. Maintaining documentation of validation results and coordinating with HHS on any future changes to submission standards will help ensure sustained compliance and prevent recurrence of similar findings in future EDV reviews.

CAHPS Analysis

Prior Year Recommendations From the EQR Technical Report for CAHPS Analysis
HSAG recommended the following: • Adult members had a less positive overall rating of all healthcare as the score for the *Rating of All Health Care* measure was statistically significantly lower than the 2023 NCQA adult Medicaid national average. HSAG recommends that **ITC** collect regular feedback throughout the year to identify member input through town halls, focus groups, and short surveys. Member advisory councils might also be considered. HSAG recommends that ITC identify trends in the data that might contribute to the lower performance through stratifying by race/ethnicity, age, ZIP Code, and gender. Once a root cause or probable reasons for lower ratings are identified, **ITC** can determine appropriate interventions, education, and actions to improve performance. • Adult members reported they did not receive medical assistance with smoking and tobacco use cessation, as the score for the *Advising Smokers and Tobacco Users to Quit* measure was statistically significantly lower than the 2023 NCQA adult Medicaid national average. HSAG recommends that **ITC** conduct provider education to ensure providers are documenting conversations about cessation strategies sufficiently and are using appropriate billing codes to do so. In one study of adults aged 65 and older, those who were advised to quit smoking by their physician gave more positive overall ratings of their care and health plan.

Prior Year Recommendations From the EQR Technical Report for CAHPS Analysis
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • ITC remains committed to enhancing member experience and satisfaction across all touchpoints. In response to identified opportunities for improvement, ITC has strengthened its oversight and feedback mechanisms through the Member & Provider Experience Council. Key actions include: o **Quarterly Review of Experience Data:** The Council systematically tracks and reviews member and provider experience survey results along with associated action plans to ensure timely and targeted interventions. o **Expanded Data Monitoring:** In 2024, the Council broadened its scope to include grievance data, enabling a more comprehensive understanding of member concerns and service gaps. o **Stakeholder Engagement:** Member feedback is actively gathered during quarterly Stakeholder Advisory Board meetings, providing ITC members with a platform to share their experiences, ask questions, and offer input on their benefits and healthcare. This valuable feedback is now systematically integrated into the Member and Provider Experience Council, ensuring that member voices are represented and directly inform our improvement strategies. o **Trend Analysis for Improvement:** Council members actively analyze experience trends to identify actionable opportunities for enhancing care delivery and member satisfaction. • In response to low performance on the CAHPS measure related to advising smokers and tobacco users to quit, Iowa Total Care (ITC) implemented targeted provider education and outreach strategies. The provider resource guide was updated to include best practices for smoking cessation counseling, aligned with CAHPS survey expectations. To ensure broad dissemination and provider engagement, the updated guide was shared electronically through email campaigns and provider newsletters. Additionally, ITC incorporated comprehensive information on smoking cessation resources available to members. These efforts reflect ITC's commitment to improving member health outcomes by equipping providers with the tools and knowledge necessary to support tobacco cessation.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Rating of Health Care increased from 49.3% to 52% • Advising Smokers and Tobacco Users to Quit increased from 66.3% to 69.4%
c. Identify any barriers to implementing initiatives: • Due to the anonymous nature of the CAHPS survey, we are unable to analyze member experience data.
HSAG Assessment: HSAG has determined that **ITC** met the prior year's recommendation. Rates for the *Rating of All Health Care* and *Advising Smokers and Tobacco Users to Quit* measures were not statistically significantly lower than the 2024 NCQA adult Medicaid national averages.

Molina Healthcare of Iowa, Inc.

Validation of Performance Improvement Projects

Prior Year Recommendations From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • HSAG did not identify any weaknesses through the PIP activity. HSAG recommends **MOL** ensure that it follows the approved PIP methodology to calculate and report the baseline data accurately in the next annual submission.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Molina followed the PIP methodology to calculate and report the baseline data in the 2025 submission.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
c. Identify any barriers to implementing initiatives: • There were no identified barriers for Molina in using the PIP methodology to calculate and report baseline data for the 2025 submission.
HSAG Assessment: HSAG determined that **MOL** addressed the prior year's recommendation. The MCO followed the approved PIP methodology to calculate and report the baseline data accurately.

Performance Measures

Prior Year Recommendations From the EQR Technical Report for Performance Measures
HSAG recommended the following: • HSAG identified a discrepancy between **MOL**'s *MLTSS-6* data output files and the numerator counts for short-term stay members across all age stratifications. Numerator counts in the data output files should match those in **MOL**'s calculated rates. HSAG recommends that **MOL** conduct a peer review validation process of all data output files and performance measure rates for numerator and denominator counts and specification alignment prior to auditor or HHS submission.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • For MY2024 Performance Measure Validation (PMV), the member level template has been expanded to include additional columns which have been used for validation and to ensure that accurate data has been reported. The MY2024 template now includes all relevant claim details, which has been validated against

Prior Year Recommendations From the EQR Technical Report for Performance Measures
the summary level rate reporting template (RRT) to make sure that all the counts are in line. The final data output files have also been peer reviewed for further accuracy and validation.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For MY2024 PMV, Molina noted improved accuracy of the Member Level Data (MLD) output file. Additionally, the peer review assisted in improved output reporting performance and count comparison between the MLD file and RRT file.
c. Identify any barriers to implementing initiatives: • There are currently no barriers to implementing these new processes.
HSAG Assessment: HSAG has determined that **MOL** addressed the prior year's recommendations based on the MCO's reported initiatives to address identified discrepancies in its output files and numerator counts for short-term stay members across all age stratifications.

Compliance Review

Prior Year Recommendations from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **MOL** had five elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. While **MOL** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary. • **MOL** had five elements within the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of authorization decisions, including decisions that result in an ABD to the member. While **MOL** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services. Further, HSAG recommends that the MCO begin preparations to implement the new seven calendar day authorization time frame, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Molina Healthcare of Iowa (Molina) conducted a letter audit, reviewing letters sent to members for compliance, ensuring letters are written in 12-point font and have the correct taglines in the Prevalent Non-English languages for Iowa, as well as conspicuously visible font. Letters that needed remediation were identified and corrections have been issued. A full materials lifecycle was established to outline a continuous audit cycle in collaboration across all functional areas. Iowa Health and Human Services (IA HHS) approved and updated the communication policy and trained the health plan staff.

Prior Year Recommendations from the EQR Technical Report for Compliance Review
• Molina reviews and updates its processes, procedures, and audit tools to ensure compliance with all federal and State obligations specific to coverage and authorization annually or as regulations are updated. All revised policies are reviewed by the Policy Committee and staff members receive training after the policies are formally approved. Managers conduct a review of a random sample of cases every month and report results to the leadership team. • Molina implemented the seven-day turnaround time to align with the SFY2025 Pay for Performance Measures ahead of the Prior Authorization final rule effective date of January 2026. All policies, procedures, processes, and handbooks have been updated to reflect the new rule timeframes. Molina has achieved 99.8% seven-day turnaround time since October 2024.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The materials audit cycle has provided insight into materials that need to be remediated during the system configuration process to ensure compliance.
c. Identify any barriers to implementing initiatives: • The evolving landscape of member rights and responsibilities has presented notable challenges particularly in ensuring the correct terminology is consistently used throughout our communications and documentation. Despite these challenges, our ongoing audit and remediation cycle has proven effective. This process allows us to regularly review and update our language and terminology, making it possible to identify necessary changes and improvements. By doing so, we ensure that we continue to meet the needs of our members and maintain clarity and accuracy in our information.
HSAG Assessment: HSAG has determined that **MOL** addressed the prior year's recommendations based on the MCO's reported initiatives for the Coverage and Authorization of Services program area. The MCO's response addressed the gaps noted regarding adherence to State and federal requirements and timely notification for authorization decisions to members. HSAG has determined that **MOL** partially addressed the prior year's recommendations based on the MCO's reported initiatives for the Member Rights and Member Information program area. The MCO's response addressed adherence to State and federal requirements regarding member materials; however, HSAG recommends that the MCO also address how it ensures provider directory updates in a paper format are made timely and how inconsistencies between information included in online and paper directories will be mitigated.

Network Adequacy Validation

Prior Year Recommendations From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **MOL** did not use HHS' standards and indicators for appointment wait times when conducting provider surveys, and the survey was conducted outside of the time frame in scope of review. HSAG recommends that **MOL** work with HHS to fully understand the appointment wait time standards and indicators and revise its survey protocol to accurately measure compliance with State standards.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

Prior Year Recommendations From the EQR Technical Report for Network Adequacy Validation
• Molina collaborated with Iowa Health and Human Services (IA HHS) to revise the telephonic script for the Provider Access and Availability surveys, ensuring the inclusion of all appointment wait time standards. The survey protocols were updated to incorporate the new IA HHS-approved script. The revised survey was fielded in December 2024, encompassing all measures that were previously omitted from the initial survey conducted in February 2024. • Specifically, the December 2024 survey assessed the following standards to ensure comprehensive evaluation of access standards: General Optometry Services: Regular Appointments and Urgent Care; Behavioral Health Access Standards: Emergency, Mobile Crisis, Urgent Substance Use Disorder and Pregnancy, and Intravenous Drug Use. • The updated survey protocol and script were utilized for the 2025 survey to accurately measure compliance with all access standards.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In collaboration with IA HHS, Molina made updates to the survey scripting to include the measurements for all access standards.
c. Identify any barriers to implementing initiatives: • There were no barriers to implementing the improved survey protocol.
HSAG Assessment: HSAG has determined that **MOL** fully addressed the prior year's recommendation by collaborating with HHS to understand appointment wait time standards and revising the survey script to conduct a survey with previously omitted indicators.

Encounter Data Validation

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • A significant weakness identified in **MOL**'s encounter data is the presence of duplicate encounters, particularly within pharmacy encounters, where the duplicate rate reached 10.0 percent. Professional and institutional encounters exhibited moderate duplication rates of 7.7 percent or lower. To reduce duplicate encounters, **MOL** should implement enhanced duplicate detection protocols to identify and prevent unnecessary claim resubmissions. Strengthening internal validation processes before submission to HHS can help detect potential duplicates at the provider and system levels. Conducting a root cause analysis to determine whether duplicate submissions stem from billing system workflows, provider resubmissions, or claim adjustments can provide targeted solutions for improvement. Additionally, **MOL** should collaborate with HHS to refine resubmission guidelines to ensure that necessary claim corrections are captured while avoiding unnecessary duplications. Providing training for providers and internal claims processing teams on proper resubmission procedures and system controls can help minimize duplicate encounter rates. Lastly, regular audits of encounter data can help track and mitigate duplicate trends, improving the accuracy, completeness, and reliability of MOL's data reporting. By addressing this weakness, **MOL** can enhance the integrity of its encounter data, ensuring that reported service utilization and financial calculations accurately reflect the care provided while reducing potential discrepancies in healthcare program monitoring and evaluation.

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
• A notable weakness identified in **MOL**'s encounter data is the lower-than-expected validity rates for a certain key data element in professional and institutional encounters. To improve the validity of drug code reporting, particularly for inpatient crossover encounters, **MOL** should implement a combination of system enhancements, provider training, data audits, and standardized reporting practices. Strengthening system validation rules by incorporating automated cross-checks against the National Drug Code (NDC), Healthcare Common Procedure Coding System (HCPCS), and formulary databases will help detect incorrect or unrecognized drug codes before submission. Additionally, real-time alerts for mismatched or outdated codes can further reduce reporting errors. **MOL** should also provide targeted training for providers and billing staff, ensuring they have clear guidance on proper *Drug Code* usage, formulary alignment, and crosswalk procedures. To further enhance data integrity, regular audits of *Drug Code* submissions should be conducted, with a focus on identifying patterns of incorrect coding and ensuring consistency across high-risk categories such as inpatient crossover encounters. Finally, collaborating with HHS and institutional providers to standardize *Drug Code* reporting requirements will help ensure that inpatient pharmacy claims are accurately captured in encounter data. By implementing these improvements, **MOL** can enhance the accuracy of *Drug Code* field reporting, reduce errors in encounter data, and ensure a more reliable representation of medication utilization trends. • The record surplus rate for pharmacy encounters exceeded a 5.0 percent threshold. HSAG recommends that **MOL** collaborate with HHS to confirm encounter submission standards for adjusted and corrected claims. Aligning submission practices will help ensure that corrected encounters are properly processed and do not contribute to surplus rates. • **MOL** had a low element accuracy rate (below 95.0 percent) for the Rendering Provider National Provider Indicator (NPI) data element, and a low element accuracy rate for the *Secondary Diagnosis Code*(s) data element for institutional encounters. HSAG recommends that **MOL** collaborate with HHS to confirm encounter submission standards for these data elements to ensure consistency in reporting. Additionally, **MOL** should implement standardized quality control measures to improve data extraction accuracy and prevent discrepancies related to provider identifiers and diagnosis coding. Strengthening internal validation processes will help ensure alignment with HHS expectations and enhance data reliability.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Molina has internal controls to identify duplicates and pend the Encounters for manual review and send them to recovery as needed. Molina's Encounters team works with Iowa Health and Human Services (IA HHS) on a bi-weekly basis to review any potential duplicates and resolve in a timely manner. Since 2024, Molina's duplicate encounters are less than 0.1% of total encounter submissions. • Molina's internal controls identify claims with missing key data elements and reject them back to the provider. Molina also has controls in place to pend outbound encounters for manual review in cases where there are key data elements missing. These claims are reviewed with provider relations and training is provided to providers on a needed basis. • Molina reviews encounter data on a periodic basis and works with IA HHS to reduce errors per their guidance. Since 2024, Molina's encounter acceptance rate is around 99.9%.

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
• Molina reviews pharmacy encounter data on a periodic basis, seeking guidance from IA HHS as needed to correct any encounter issues. Since 2024, Molina's pharmacy encounter acceptance rate has been around 99.9%.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Molina's encounter data quality and submissions improved from 2024 compared to the initial implementation phase of Q1 and Q2 of FY 2023 after actively working with IA HHS and the Claims Operation team in resolving the issues. Molina's acceptance rates are consistently above 99%. IA HHS acknowledged the results in their annual performance report.
c. Identify any barriers to implementing initiatives: • None
HSAG Assessment: HSAG has determined that **MOL** fully addressed the recommendations. **MOL** described comprehensive initiatives and implemented corrective actions that directly align with HSAG's guidance across all identified issue areas, including duplicate encounters, *Drug Code* field validity, record surplus for pharmacy encounters, and low element accuracy for the *Rendering Provider NPI* and *Secondary Diagnosis Code(s)* data elements. **MOL** implemented internal controls to identify and pend duplicate encounters for manual review, established regular coordination with HHS to review and resolve duplicates, and reported a substantial reduction in duplicate encounters to less than 0.1 percent of total submissions since 2024. These actions directly address the previously elevated duplication rates and demonstrate effective root cause mitigation and ongoing oversight. **MOL** also strengthened internal validation and quality control processes to improve data accuracy and completeness, including rejecting claims with missing key data elements, delaying manual reviews, and targeting provider training when deficiencies are identified. **MOL**'s collaboration with HHS to confirm submission standards for adjusted claims, pharmacy encounters, provider identifiers, and diagnosis coding further supports alignment with state expectations. Reported performance improvements, including encounter and pharmacy acceptance rates that are consistently above 99.0 percent and acknowledgment from HHS in its annual performance report, provide evidence the implemented initiatives have resulted in measurable and sustained improvements in encounter data quality. **MOL** reported no barriers to implementing these initiatives, indicating that the corrective actions were integrated smoothly into existing workflows. To maintain and build upon these improvements, HSAG recommends that **MOL** continue routine audits of encounter data, periodically reassess duplicate detection logic as submission practices evolve, and maintain ongoing collaboration with HHS to address any future changes in encounter submission requirements. Continued documentation of monitoring results and provider education efforts will help ensure sustained compliance and prevent recurrence of similar issues in future EDV reviews.

CAHPS Analysis

Prior Year Recommendations From the EQR Technical Report for CAHPS Analysis
HSAG recommended the following: • **MOL** was a new MCO in Iowa effective July 1, 2023; therefore, the MCO did not have CAHPS data for CY 2024.

Prior Year Recommendations From the EQR Technical Report for CAHPS Analysis
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: NA

Wellpoint Iowa, Inc.

Validation of Performance Improvement Projects

Prior Year Recommendations From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • HSAG did not identify any weaknesses through the PIP activity. HSAG recommends **WLP** ensure that it follows the approved PIP methodology to calculate and report the baseline data accurately in the next annual submission.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Wellpoint (WLP) Iowa has actively implemented several initiatives to ensure compliance with the approved PIP methodology and address HSAG's recommendations. Activities included a detailed review and recalibration of the data collection and reporting processes to enhance accuracy in baseline data reporting. Specific initiatives involved compliance checks and validation processes aligned with Healthcare Effectiveness Data and Information Set (HEDIS) and CMS methodologies. The quality improvement team and provider success consultants were actively engaged to ensure proper documentation and adherence to guidelines. Additionally, ongoing training and support for providers and staff were initiated to reinforce the understanding of data requirements and methodologies. • Efforts have also been made to streamline the integration of new performance indicators and recalibrate existing initiatives to better capture relevant data. Corrective actions included cross-referencing current data collection practices against state and federal guidelines to identify any discrepancies or areas for improvement. Enhanced education sessions for providers regarding the measure timeframes and components were implemented to ensure comprehensive understanding and compliance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result of these initiatives, Wellpoint Iowa noted marked improvements in data accuracy and intervention outcomes. For instance, there has been a measurable increase in the participation rates within the Social Drivers of Health Provider Incentive Program, as evidenced by the increase in completed assessments in the selected provider group. Similarly, for the Attention-deficit/hyperactivity disorder (ADHD) medication follow-up care PIP, improvements were observed in maintaining member engagement through strategic communication and enhanced provider incentives, leading to better compliance rates. • Performance was noted in the Initiation Phase and Continuation and Maintenance Phase of ADHD medication management, indicating an incremental improvement in member oversight and provider accountability.
c. Identify any barriers to implementing initiatives: • Some barriers to the effective implementation included challenges associated with maintaining consistent provider engagement and overcoming limitations in provider resources. There were also concerns regarding misunderstanding or misinterpretation of measure timeframes, which required additional provider education.

Prior Year Recommendations From the EQR Technical Report for Performance Improvement Projects
• Data completeness and validity remained an area needing continuous monitoring due to claims processing lags. Moreover, technological barriers, such as member access to the internet or digital platforms for interventions, and the training of providers on new data tools and technologies, posed notable challenges that needed addressing. • To address these barriers, Wellpoint Iowa implemented support systems and training programs that have started to mitigate some of the technological and engagement challenges, fostering an environment where successful data-driven interventions can be expanded and scaled effectively.
HSAG Assessment: HSAG determined that **WLP** addressed the prior year's recommendation. The MCO followed the approved PIP methodology to calculate and report the baseline data accurately.

Performance Measures

Prior Year Recommendations From the EQR Technical Report for Performance Measures
HSAG recommended the following: • **WLP**'s performance in the Access to Preventive Care domain remained low, as the *Use of Imaging Studies for Low Back Pain* measure ranked below the 25th percentile. HSAG recommends that **WLP** ensure providers are aware of best practices regarding imaging studies for low back pain, such as avoiding diagnostic imaging in the first four weeks of new-onset back pain, unless red flags or other conditions are present, and encouraging management of back pain through regular physical activity, healthy back exercises, and education on injury prevention. HSAG recommends that **WLP** consider using quality interventions that have been shown to improve appropriate imaging studies for low back pain, including increased provider oversight, providers getting education about HEDIS specifications, specific imaging prompts in the EMR, and quality scorecards for providers. • **WLP**'s performance in the Women's Health domain remained low, as the *Chlamydia Screening in Women* measure ranked below the 25th percentile. HSAG recommends that **WLP** research interventions discussed in an NCQA performance improvement article, including provider outreach and education, member education and outreach, the tracking of chlamydia screening rates and reporting those results to physicians and large practices. HSAG recommends that **WLP** consider requiring providers to use Logical Observation Identifiers Names and Codes (LOINC), which creates an electronic record of the screening test. HSAG recommends that **WLP** consider requiring labs to report tests directly to health plans, in addition to the usual reports sent to providers. • **WLP** s performance in the Behavioral Health domain remained low, as the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total indicator* ranked below the 25th percentile. HSAG recommends **WLP** assess how providers are coordinating on antipsychotic care. In one study, members who saw a PCP and mental health provider over the year had a higher rate of receiving metabolic monitoring. Therefore, encouraging joint monitoring might increase the rate of metabolic monitoring. Further, HSAG recommends **WLP** generate provider data reports to identify trends in whether providers are prescribing antipsychotics and not doing metabolic monitoring. • During source code review and PSV, HSAG noted multiple areas of specification misalignment. **WLP** also noted the omission of the measure value sets within its source code and use of the same continuous enrollment criteria across all three MLTSS measures. HSAG recommends that **WLP** implement a multi-layer peer review approach to source code and data output review and approval, using peer review

Prior Year Recommendations From the EQR Technical Report for Performance Measures
processes at the developer, analytics, and management level to ensure full application and alignment of the specifications. HSAG also recommends that **WLP** conduct ongoing internal PSV on a subset of cases each month for assurance in specification alignment and rate calculations.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Increased communication with providers regarding HEDIS measures and best practices. Addition of targeted HEDIS measures in value-based contracts for improvement areas for both the providers and Wellpoint to promote optimal health outcomes for our members. • Working with provider groups to increase supplemental data submission. • Wellpoint is committed to developing and refining our reporting logic to align with the criteria and specifications outlined in the Medical Long-Term Services and Supports (MLTSS) Quality Measures Technical Specifications and Reporting Manual. To achieve this, we have established a dedicated team comprising data analysts, a developer, and an MLTSS leader. This team is focused on reviewing and enhancing the criteria to ensure that complex data elements are accurately and appropriately represented.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Measurement year 2024 (reporting year 2025) results for the APM (Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total) and CHL (Chlamydia Screening in Women—Total) measures remain below goal. • Throughout the data review and validation activities, inaccurate or missing claim information is noted. Wellpoint has a dedicated Long-Term Services and Supports (LTSS) trainer embedded within the LTSS provider experience team dedicated to provide training and develop resources for our LTSS providers, which includes nursing facility providers. The dedicated trainer can provide targeted training for a specific provider and larger audiences.
c. Identify any barriers to implementing initiatives: • Data sharing between providers and Wellpoint. Measurement year 2024 (reporting year 2025) has shown a barrier with data sharing between providers and Wellpoint. Wellpoint is actively pursuing additional opportunities to increase submission of supplemental data and other digital capabilities to address this barrier which has contributed to the limited movement in scores around chlamydia screening, monitoring of glucose and cholesterol in children and adolescents prescribed antipsychotics, and the appropriate use of imaging for low back pain. • Inaccurate claim information can pose specific challenges to reporting. In some instances, claims are submitted without a discharge date or identifying the number of bed days. There have also been instances of the incorrect discharge status entered on the claim form. The CMS technical specifications are rather complex and have posed challenges with ensuring the criteria is interpreted correctly, allowing the source code to pull data from our internal systems correctly. • One challenge we are currently addressing is the impact of inaccurate claim data affecting the quality of reporting. To counteract this, we are actively developing and refining analytical reporting tools that prioritize accuracy and consistency with the CMS technical specifications for each measure.

Prior Year Recommendations From the EQR Technical Report for Performance Measures
HSAG Assessment: HSAG has determined that **WLP** addressed the prior year's recommendations based on the MCO's reported initiatives. Although **WLP** developed improvement strategies based on the prior year's recommendations (i.e., interventions) that are designed to target the population(s) and age group(s) to successfully improve member outcomes, there is additional room for improvement with measures that declined in performance or did not meet the national benchmarks.

Compliance Review

Prior Year Recommendations From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **WLP** had five elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. While **WLP** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary. • **WLP** had four elements in the Coordination and Continuity of Care program area that received a score of *Not Met*, indicating members' care may not be effectively coordinated through the care management program. While **WLP** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members. • **WLP** had four elements in the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of authorization decisions, including decisions that result in an ABD to the member. While **WLP** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services. Further, HSAG recommends that the MCO begin preparations to implement the new seven calendar day authorization time frame, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • STD II.03: WLP has updated its member handbook to include language that reflects each member's right to dignity and privacy, specifically around members' rights to fully participate in the community and to work, live, and learn to the fullest extent possible without restriction in any way from WLP. • STD II.04: WLP has updated grade level requirements and created consistent language in its policies and procedures to remove any confusion (i.e., 5.9 versus 5th grade reading level).

Prior Year Recommendations From the EQR Technical Report for Compliance Review
• STD II.07: WLP has identified the causes of and corrected non-compliant font sizes and formatting of the Spanish tagline on the submitted Member Welcome Packet and Member Handbook. WLP has updated the internal market rules used by Marketing when creating or revising member marketing materials to reflect correct tagline formatting (English and Spanish both 18 pt in bold) moving forward. • STD II.22: WLP expanded language in its New Member Packet to explicitly state members may request a printed copy of the handbook at no cost and receive it within five business days. WLP has also worked with the Document Request Tool (DRT) team to change WLP's service level agreement to four business days to ensure compliance with this timeline. • STD II.23: WLP is actively working across multiple teams and distribution platforms to build a cohesive member communication preferences framework with completion of the project tentatively determined for Q2 2026. • Improved dental care coordination through direct communication and appointed liaisons. • In process of improving medical record review processes with creation of new process and assigning responsible departments/associates to complete reviews. • More personalized care plans resulting from better cultural considerations documentation practices. • Faster service authorization due to streamlined processes, reducing delays. • In process of improving readability and clarity of ABD notices, to align with recommendations. Updated notice is in draft form for business owner reviews. • Accurate adherence to the 72-hour turnaround time for Utilization Management (UM) systems. UM system updates were completed to flag turnaround times accurately. Procedure has been updated to reflect 72 hours instead of 3 calendar days.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Improved dental care coordination through direct communication and appointed liaisons. • Enhanced compliance rates due to improved medical record review processes. • More personalized care plans resulting from better cultural considerations documentation practices. • Faster service authorization due to streamlined processes, reducing delays. • Improved readability and clarity of ABD notices, aligning with recommendations. • Accurate adherence to the 72-hour turnaround time for UM systems.
c. Identify any barriers to implementing initiatives: • Lengthy case management documentation platform changes may slow implementation. • Potential provider abrasion due to revised peer-to-peer and appeals process communications. • System implementation processes are laborious and may take months. • Extended time needed to integrate updated letters into UM systems.
HSAG Assessment: HSAG has determined that **WLP** addressed the prior year's recommendations based on the MCO's reported initiatives for the Member Rights and Member Information program area. The MCO's response addressed the gaps noted regarding adherence to State and federal requirements and timely notification for members to receive a copy of the member handbook. Additionally, HSAG has determined that **WLP** addressed the prior year's recommendations based on the MCO's reported initiatives for the Coverage and Authorization of Services program area. The MCO's response addressed the gaps noted regarding timely and adequate notice of authorization decisions, including decisions that result in an ABD to the member.

Prior Year Recommendations From the EQR Technical Report for Compliance Review
Lastly, HSAG has determined that **WLP** partially addressed the prior year's recommendations based on the MCO's reported initiatives for the Coordination and Continuity of Care program area. The MCO's response addressed the gap pertaining to personalized care plans; however, HSAG recommends that the MCO also implement initiatives to ensure initial screenings are completed timely; prioritized goals in member's service plans are documented; and care managers consistently adhere to the check-in schedule to monitor members' progress and ensure documentation in the members' records.

Network Adequacy Validation

Prior Year Recommendations From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **WLP** did not use HHS' standards and indicators for appointment wait times when conducting provider surveys. HSAG recommends that **WLP** work with HHS to fully understand the appointment wait time standards and indicators and revise its survey protocol to accurately measure compliance with State standards.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Emergency Care   ○ Wellpoint plans to add specific emergency care survey questions and modify response options to reflect immediate response as the appropriate standard in the Appointment Availability survey. Our Health Link Contract identifies hospitals and behavior health; we plan to identify these two responder types to receive the appropriate survey question. • BH - Mobile Crisis • Wellpoint has identified that all Certified Community Behavioral Health Clinics (CCBHC) are required to offer mobile crisis services to individuals in their respective service areas. Wellpoint is in the process of collaborating with each of the CCBHCs to obtain their policies and procedures related to their mobile crisis response services. These policies and procedures must include documentation of response times, including the 1-hour response requirement, as outlined in the CCBHC participation requirements.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None.
c. Identify any barriers to implementing initiatives: • None.
HSAG Assessment: HSAG has determined that **WLP** fully addressed the prior year's recommendations by reviewing state standards, modifying response options, updating providers for emergency care inclusion, and sending these changes to their third-party survey vendor for review, with the intent to send to HHS for final approval.

Encounter Data Validation

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **WLP** had a low element accuracy rate (below 95.0 percent) for the *Secondary Diagnosis Code(s)* data element and lower-than-expected element accuracy rate for the *Primary Diagnosis Code* data element within the institutional encounters. HSAG recommends that **WLP** collaborate with HHS to clarify and align encounter submission standards for diagnosis coding. This includes confirming expectations for the number and type of diagnosis codes that should be reported to ensure consistency in data processing. Additionally, **WLP** should refine its data extraction protocols by implementing validation checks that distinguish between required and supplemental diagnosis codes. Establishing clear internal guidelines for diagnosis code inclusion will help reduce discrepancies, improve alignment with HHS standards, and enhance the accuracy of encounter data submissions. Regular audits and monitoring of extracted diagnosis codes can further ensure compliance with standardized reporting expectations and reduce future data integrity issues.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • WLP has reviewed the script used to pull audit data and identified that the discrepancy occurred because the audit script extracted all available diagnosis codes, rather than limiting the output to those requested in the audit file layout. To address this, we have updated our process to ensure closer alignment with expectations. For future audits, WLP will obtain clarification of the audit data element requirements, test the audit file output against those clarified requirements, and conduct internal reviews of the files prior to submission. This will help ensure accuracy and consistency in how diagnosis codes are extracted and reported.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The revised audit data pull will improve alignment between expected and reported diagnosis codes. These adjustments are expected to result in higher element accuracy rates for both Primary and Secondary Diagnosis Codes, with anticipated improvement in future audits once the new validation and review process is fully in place.
c. Identify any barriers to implementing initiatives: • The primary barrier is the need to confirm audit data element requirements with HSAG to ensure there is no misinterpretation of standards. In addition, testing and review steps require coordination across Encounters Business and Reporting teams to validate changes to extraction scripts. Despite these dependencies, WLP is committed to building this clarification and validation process into its standard audit preparation workflow to prevent recurrence.
HSAG Assessment: HSAG has determined that **WLP** has partially addressed the recommendations. **WLP** appropriately identified the root cause of the low-element accuracy rates for the *Primary* and *Secondary Diagnosis Codes* data elements, specifically, that its audit script extracted all available diagnosis codes rather than limiting output to the codes requested in the audit file layout. **WLP** described corrective actions that align with HSAG's recommendations, including revising the extraction process, planning to clarify the audit data

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
element requirements in advance, testing audit outputs against clarified standards, and conducting internal reviews prior to submission. These steps demonstrate an understanding of the issue and a reasonable approach to improving alignment with HHS' expectations. However, the described improvements are largely prospective, and **WLP** did not report measurable performance improvements at this time. While the revised audit data pull is expected to improve diagnosis code accuracy in future submissions, the absence of implemented outcomes or demonstrated improvement limits the ability to conclude that the recommendations have been fully addressed. As such, the recommendations remain partially addressed pending evidence that the updated processes consistently result in improved primary and secondary diagnosis code accuracy. **WLP** identified clarification of audit data element requirements and the need for cross-team coordination as key barriers to implementation. To strengthen its response, HSAG recommends that **WLP** formalize documentation of clarified diagnosis code reporting standards, incorporate routine validation checks that distinguish required versus supplemental diagnosis codes, and track post-implementation accuracy trends through periodic audits. Establishing defined timelines for completing testing and implementation, along with ongoing collaboration with HHS and HSAG, will be important to ensure sustained improvement and prevent recurrence of similar findings in future EDV reviews.

CAHPS Analysis

Prior Year Recommendations From the EQR Technical Report for CAHPS Analysis
HSAG recommended the following: • Parents/caretakers of child members in the CCC Medicaid population reported less positive overall experiences in coordinating their child's chronic conditions, as the *Coordination of Care for Children With Chronic Conditions* measure was statistically significantly lower than the 2023 NCQA CCC Medicaid national average. HSAG recommends that **WLP** solicit feedback from parents/caretakers through surveys or town halls to identify specific concerns for follow-up. HSAG recommends that **WLP** consider family and child members co-design of interventions involving care coordination, as that can broaden the range of ideas and might improve overall effectiveness. One study discusses care coordination approaches shown to be effective for child members with chronic conditions, which include having a team-based organization of care, a designated care coordinator, digital information sharing, as well as completing care plans and member registries. Examples of information that can be shared digitally with children, family, and the care team include pre-visit summaries, care plans, and medical summaries.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Increased awareness of Consumer Assessment of Healthcare Providers and Systems (CAHPS) with the stakeholder advisory board with member representatives. • Interdepartmental collaboration to solicit member feedback.

Prior Year Recommendations From the EQR Technical Report for CAHPS Analysis
• Increased partnerships with Medicaid providers to discuss CAHPS results to help identify interventions that may assist with improving the member's overall experience.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Overall health plan rating for the Consumer Choices Option (CCC) Medicaid population continued to be below goal for reporting year 2025.
c. Identify any barriers to implementing initiatives: • No barriers identified.
HSAG Assessment: HSAG has determined that **WLP** met the prior year's recommendations. The rate for *Coordination of Care for Children With Chronic Conditions* was not statistically significantly lower than the 2024 NCQA CCC Medicaid national average.

6. Follow-Up on Prior EQR Recommendations for PAHPs

Delta Dental of Iowa

Validation of Performance Improvement Projects

Prior Year Recommendations From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **DDIA** demonstrated a statistically significant decrease in performance for the first and second performance indicators. HSAG recommends that **DDIA** revisit its causal barrier analysis to determine if any new barriers exist for the adult and Hawki populations that require the development of targeted strategies to improve performance.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • DDIA provided sufficient barrier analysis for these two indicators demonstrating a decrease in statistical significance. DDIA has continued to monitor these barriers and identify improvements, such as expanding care coordination programming and introducing new communication plans and methods for outreach.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable
c. Identify any barriers to implementing initiatives: • Not applicable
HSAG Assessment: Based on the documentation, HSAG has determined that **DDIA** addressed the prior year's recommendations. The PAHP monitored barriers and identified improvements.

Performance Measures

Prior Year Recommendations From the EQR Technical Report for Performance Measures
HSAG recommended the following: • During review of the Rate Reporting Template with member-level detail, HSAG observed source code restrictions applied to numerator compliance for the *DWP Unique Members With 6+ Months Coverage and Accessing Any Dental Care and DWP Members Who Received Preventive Dental Care* measures. HSAG recommends that **DDIA** conduct additional review of the measurement specifications and conduct visual validation of the rate template using filters or formulas prior to HHS or HSAG submission to ensure all data are reported accurately against the technical specifications. • During review of the Rate Reporting Template with member-level detail, HSAG observed that DDIA included third party liability claims for members who had commercial insurance, but for which Medicaid

Prior Year Recommendations From the EQR Technical Report for Performance Measures
did not pay for any secondary coverage. HSAG recommends that **DDIA** conduct additional review of the measurement specifications and conduct visual validation of the rate template using filters or formulas prior to HHS or HSAG submission to ensure all data are reported accurately against the technical specifications.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • DDIA has implemented additional internal validation checks, such as peer specification and code reviews, of the Rate Reporting Template prior to submission. DDIA also conducts the appropriate signoffs prior to submission and has hired another data analyst who assists in the collection and visual validation of all data.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Additional validation checks of the data provide for a higher confidence level in data submission accuracy and downstream reporting.
c. Identify any barriers to implementing initiatives: • Not applicable
HSAG Assessment: HSAG has determined that **DDIA** addressed the prior year's recommendations based on the PAHP's reported initiatives.

Compliance Review

Prior Year Recommendations From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **DDIA** had three elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. While **DDIA** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the PAHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • DDIA conducted a working session to perform a comprehensive review of DDIA's Provider Manuals, Screening Center Manual, Member Handbooks, Member Notices, Taglines document, and the Provider Directory to ensure that the applicable content was incorporated and addressed for program compliance. The Member Handbooks and Provider Manuals also underwent a formatting change for easier navigation across sections. DDIA has provided the Provider Manuals on our public website and created a procedure for reviewing the reading level of member-facing documents. DDIA also reviewed and updated our internal policy, Government Programs Information Requirements Policy-Procedure, to provide additional staff

Prior Year Recommendations From the EQR Technical Report for Compliance Review
guidance on member-facing documents to ensure continued alignment with timelines and required content. These activities have been completed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • With the creation of the reading level procedure, additional staff have been trained in how to effectively review and update the reading level of member documents. They have also been provided with new and updated tools to ensure accessibility (for example: glossaries for required terminology and other templates). Also, DDIA has developed a Government Programs Document Tracker which outlines various program documents, reading level, font checks, review status, etc.
c. Identify any barriers to implementing initiatives: • Not applicable
HSAG Assessment: HSAG has determined that **DDIA** addressed the prior year's recommendations based on the PAHP's reported initiatives for the Member Rights and Member Information program area. The PAHP's response addressed the gaps noted regarding adherence to State and federal requirements and provider directory required components.

Network Adequacy Validation

Prior Year Recommendations From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • No specific opportunities were identified related to the data collection and management processes that **DDIA** had in place to inform network adequacy standard and indicator calculations.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: NA

Encounter Data Validation

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • Almost 10.0 percent of the *Dental Procedure Code* data element identified in the encounter data were not supported by the members' dental records. To address this finding, **DDIA** should introduce a pre-submission checklist for providers to verify the completeness of their dental records before submission. Enhancing internal validation processes in **DDIA**'s workflows could also help identify incomplete or inaccurate records prior to submission to HHS. Finally, **DDIA** should establish clear documentation standards for the *Dental Procedure Code* data element and consider linking provider performance metrics to adherence to these standards to drive improvements in record accuracy and completeness. • More than 20.0 percent of the dates of service present and matching in both data sources did not contain accurate values for the dental procedure code(s). **DDIA** should focus on directly improving coding accuracy. This effort should include conducting targeted audits of *Dental Procedure Code* data element submissions to identify common errors, particularly for providers with high omission rates. Additionally, **DDIA** should develop specialized training modules for providers, focusing on accurate coding practices and addressing common mistakes with actionable guidance. Utilizing data analytics to monitor patterns of inaccuracies in the *Dental Procedure Code* data element would provide valuable insights to guide training efforts and process improvements. Finally, **DDIA** should enhance its communication with providers by offering regular feedback on coding accuracy and providing tailored recommendations to address specific issues.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • DDIA will be performing an internal audit to review the records with noted discrepancies to locate areas needing additional education, such as coding practices, and support from our network providers. From this internal review and using the list of areas identified as needing improvement, a checklist form will be developed to ensure providers and provider offices are making complete submissions when it comes to member information and services. This checklist and additional education will be included in DDIA's newsletters and Provider Manuals. Although initiated, these activities are still underway with an implementation timeline of Spring 2026.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable
c. Identify any barriers to implementing initiatives: • The plan for correcting these recommendations has been developed, but due to staffing changes, the actual development of these documents and education has been delayed.
HSAG Assessment: HSAG has determined that **DDIA** partially addressed the prior year's recommendations. **DDIA** acknowledged the identified issues related to the *Dental Procedure Code* data element completeness and accuracy and described several planned activities that align with HSAG's recommendations, including conducting an internal audit of discrepant records, identifying areas requiring additional provider education, and developing a pre-submission checklist to support more complete and accurate provider submissions. **DDIA** also indicated plans to incorporate the checklist and related education into provider-facing materials, such as

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
newsletters and manuals, which demonstrate an appropriate understanding of the root causes and a reasonable strategy to address them. However, these initiatives are still underway and **DDIA** reported that no measurable performance improvement is available at this time. The lack of implemented outcomes or documented improvements in coding accuracy or record completeness limits the ability to determine whether the planned actions have been effective. While the response reflects intent and planning consistent with the recommendations, the recommendations cannot be considered fully addressed until the initiatives are implemented and result in demonstrable improvements. **DDIA** identified staffing changes as a key barrier that delayed the development and rollout of the checklist and provider education materials. To strengthen future efforts, HSAG recommends that **DDIA** establish more defined interim milestones and timelines to ensure progress despite staffing constraints. After implementation, **DDIA** also should prioritize monitoring outcomes through targeted audits and data analytics, and regularly distribute provider-specific feedback on coding accuracy. Linking these monitoring activities to ongoing training and performance expectations may help sustain improvement and reduce the likelihood of similar findings in future EDV reviews.

Managed Care of North America Dental

Validation of Performance Improvement Projects

Prior Year Recommendations From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **MCNA** demonstrated a decline in performance as compared to the baseline for the first performance indicator. HSAG recommends that MCNA revisit its causal barrier analysis to determine whether any new barriers exist for the adult population that require the development of targeted strategies to improve performance.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • MCNA's first PIP indicator showed a slight decline of 0.57 percentage points in SFY24 compared to the baseline. In response, and as part of our ongoing quality improvement efforts, the Quality Improvement (QI) team revisited its causal/barrier analysis with a renewed focus on identifying new challenges impacting the adult population. Using a fishbone diagram, the team explored potential underlying causes and barriers that may not have been previously considered. Feedback was also solicited from network providers during quarterly Quality Improvement Committee (QIC) and Dental Advisory Committee (DAC) meetings to uncover new provider- and member-level barriers. Additionally, member input was gathered through inbound calls to the Member Hotline and via Member Advocate Outreach Specialists, who engage directly with the community at outreach events. These insights informed a revised root cause analysis, which led to the implementation of a targeted provider intervention aimed at improving reporting of missed appointments.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • MCNA's first PIP indicator for the third remeasurement period (SFY25) has already improved over the baseline by 0.91 percentage points. MCNA anticipates that this rate will continue to increase as additional claims are processed during the SFY runout period, providing a more complete picture of performance outcomes.
c. Identify any barriers to implementing initiatives: • There were no barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that **MCNA** addressed the prior year's recommendations. The PAHP revisited its causal/barrier analysis and implemented targeted interventions.

Performance Measures

Prior Year Recommendations From the EQR Technical Report for Performance Measures
HSAG recommended the following: • HSAG did not identify any weaknesses during the 2024 activity.

Prior Year Recommendations From the EQR Technical Report for Performance Measures
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: NA

Compliance Review

Prior Year Recommendations From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **MCNA** had three elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. While **MCNA** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the PAHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary. • **MCNA** had four elements in the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of authorization decisions, including decisions that result in an adverse benefit determination to the member. While **MCNA** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the PAHP continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services. Further, HSAG recommends that the PAHP begin preparations to implement the new seven calendar day authorization time frame, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The Notice of Adverse Benefit Determination (NABD) template was updated by adding "or" effective 8/12/24 and the CDT language was updated to easily understood language effective 11/22/24. • The ticket to update the urgent standard timeframe in DentalTrac(TM) is pending completion. • Missing language regarding termination, suspension, or reduction of previously authorized services was added to the policy on 7/16/24. The policy was reviewed and approved by the QIC on 7/31/24. The revised policy was sent to the UM team via email for review on 8/26/24. Most attestations of understanding were

Prior Year Recommendations From the EQR Technical Report for Compliance Review
received from the team between 9/3/24 – 10/20/24. A second email was sent to those who had not responded on 11/21/24 and all responses were received by 12/3/24. • On 9/17/24 the standard timeframe was updated to 7 calendar days in preparation for the 2026 CMS changes. The NABD for pre-authorizations that go over the 14 calendar day or 72 hour timeframe will be completed manually. • The Iowa member handbook features a tagline in 18-pt font size about how to request materials in other formats and languages. It is at the front of the handbook before the table of contents. It doesn't say "auxiliary aids" because we use plain language to explain types of other materials they can request. • The Grievance and Appeals (G&A) Team has added the requirement for letters to be 12pt or larger in our Administrator and Coordinator working aids, in our G&A Auditing Guide, and in our working aid for our Complaints Auditors to make sure all acknowledgement letters and resolution letters are 12pt or large font. • The Compliance Department met with all business areas involved in creating member materials to review the requirement. All materials are reviewed on an on-going basis to ensure that the font size for member materials is no smaller than 12-point font.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • There are no barriers at this time.
HSAG Assessment: HSAG has determined that **MCNA** addressed the prior year's recommendations based on the PAHP's reported initiatives for the Coverage and Authorization of Services program area. The PAHP's response addressed the gaps noted regarding adherence to the requirements related to the timing of authorization decisions, including decisions that result in an ABD to the member. HSAG has determined that **MCNA** partially addressed the prior year's recommendations based on the PAHP's reported initiatives for the Member Rights and Member Information program area. The PAHP's response indicated that it updated its member handbook; however, the PAHP did not mention how it will consistently provide timely notification to members for all provider terminations. As such, HSAG recommends that the PAHP has a process in place to ensure timely notification to members for provider terminations.

Network Adequacy Validation

Prior Year Recommendations From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **MCNA** checked provider Medicaid exclusion at credentialing and recredentialing (every three years), as well as on an ad hoc basis. HSAG recommends that **MCNA** implement a monthly regular check of providers against Medicaid exclusion resources.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

Prior Year Recommendations From the EQR Technical Report for Network Adequacy Validation
• On a monthly basis, MCNA's credentialing supervisor downloads the IA Exclusions Report in Excel, sorts to limit to dentists and dental specialists only, and manually reviews for any MCNA participating providers.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • There are no barriers.
HSAG Assessment: HSAG has determined that **MCNA** fully addressed the recommendation as MCNA indicated it conducts exclusion checks monthly.

Encounter Data Validation

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • More than 10.0 percent of the *Dental Procedure Code* data element identified in the encounter data were not supported by the members' dental records. To address this finding, **MCNA** should focus on improving dental record procurement processes. This includes working with providers to ensure the submission of complete and accurate dental records for all requested cases. Strategies could include targeted outreach to non-responsive providers or implementing contractual penalties for non-compliance. Additionally, **MCNA** should introduce a pre-submission checklist for providers to verify the completeness of their dental records before submission. Enhancing internal validation processes in **MCNA**'s workflows could also help identify incomplete or inaccurate records prior to submission to HHS. Finally, **MCNA** should establish clear documentation standards for the *Dental Procedure Code* data element and consider linking provider performance metrics to adherence to these standards to drive improvements in record accuracy and completeness. • Almost 30.0 percent of the dates of service present and matching in both data sources did not contain accurate values for the dental procedure code(s). To address this finding, **MCNA** should focus on directly improving coding accuracy. This effort should include conducting targeted audits of *Dental Procedure Code* data element submissions to identify common errors, particularly for providers with high omission rates. Additionally, **MCNA** should develop specialized training modules for providers, focusing on accurate coding practices and addressing common mistakes with actionable guidance. Utilizing data analytics to monitor patterns of inaccuracies in *Dental Procedure Code* and Dates of Service data elements would provide valuable insights to guide training efforts and process improvements. Finally, **MCNA** should enhance its communication with providers by offering regular feedback on coding accuracy and providing tailored recommendations to address specific issues.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • To address the issue of unsupported Dental Procedure Code data in encounter submissions, MCNA has incorporated a dental record review component into provider trainings to emphasize the importance of

Prior Year Recommendations From the EQR Technical Report for Encounter Data Validation
submitting complete and accurate documentation. Additionally, a pre-submission checklist is underway to help providers verify record completeness prior to submission. The Provider Relations team also conducts semi-annual provider seminars that focus on common challenges, such as avoidable denials, and offer practical training on prevention and resolution strategies. To reinforce these efforts, a quarterly Practice Site Performance Summary is shared and reviewed during site visits, promoting continuous improvement. Additionally, the monthly "Coffee and Queries" virtual forum, launched in February 2025, provides real-time support and open dialogue for billing specialists, office staff, and providers. These initiatives are ongoing and continue to evolve based on provider needs and performance trends.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Notably, following expert-led training through the new Coffee and Queries series, the University of Iowa achieved a 36% reduction in third-party liability denials within four months—demonstrating the effectiveness of this approach. Additionally, dental record review scores have consistently improved quarter over quarter, reflecting greater accuracy in documentation and adherence to billing standards
c. Identify any barriers to implementing initiatives: • One challenge has been low seminar attendance, despite overwhelmingly positive feedback from Spring participants. To better understand and address this issue, Provider Relations conducted a live survey over the past four months, gathering insights on attendance barriers, preferred training topics, and scheduling preferences. Based on this feedback, the avoidable denials seminar will be rehosted this Fall with adjustments aimed at improving accessibility and engagement—reflecting MCNA's commitment to continuous improvement and provider-centered planning.
HSAG Assessment: HSAG has determined that **MCNA** partially addressed the prior year's recommendations. **MCNA** implemented several initiatives that align well with HSAG's guidance, including incorporating dental record review into provider training, developing a pre-submission checklist to support record completeness, and expanding provider education through multiple communication and training channels. The use of semi-annual provider seminars, quarterly Practice Site Performance Summaries, and the monthly "Coffee and Queries" virtual forum demonstrates a multifaceted approach to improving documentation quality, coding accuracy, and provider engagement. Importantly, **MCNA** reported early evidence of performance improvement, including measurable reductions in third-party liability denials following targeted training and consistent quarter-over-quarter improvements in dental record review scores. These outcomes suggest that the implemented strategies are directionally effective and support the intent of the recommendations. However, because some initiatives (such as the pre-submission checklist) are still underway and broader, sustained improvements in the *Dental Procedure Code* data element accuracy have not yet been fully demonstrated across the provider network, the recommendations cannot be considered fully addressed at this time. **MCNA** identified low attendance at provider seminars as a key barrier to implementation. While feedback from attendees has been positive, limited participation may reduce the overall impact of training efforts. HSAG views **MCNA**'s use of provider surveys and planned adjustments to seminar timing and format as appropriate steps to mitigate this barrier. To further strengthen its approach, HSAG recommends that **MCNA** continue expanding flexible training options (e.g., recorded sessions or targeted outreach to high-risk providers), formalize timelines for completing outstanding initiatives, and enhance routine monitoring of *Dental Procedure Code* and *Date of Service* element accuracy. Continued use of data analytics and provider-specific feedback will be critical to sustaining improvements and fully addressing the original recommendations in future EDV cycles.

7. Managed Care Plan Comparative Information

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

External Quality Review Activity Results

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

Validation of Performance Improvement Projects

For the CY 2025 validation, the MCOs submitted baseline data for the two HHS-mandated PIP topics, and the PAHPs submitted Remeasurement 3 data for the HHS-mandated PIP topics. HSAG's validation evaluated the technical methods for the MCPs' PIPs (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of each MCP's PIP and assigned an overall confidence level of *High Confidence, Moderate Confidence, Low Confidence,* or *No Confidence* for the two required validation ratings identified below.

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

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

MCP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores		
				Met	Partially Met	Not Met	Met	Partially Met	Not Met
ITC	*SDOH Screening*	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
MOL	*SDOH Screening*	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		

MCP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores		
				Met	Partially Met	Not Met	Met	Partially Met	Not Met
WLP	*SDOH Screening*	*Low Confidence*	*Not Assessed*	88%	12%	0%	*Not Assessed*		
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	*Low Confidence*	*Not Assessed*	94%	6%	0%	*Not Assessed*		
DDIA	*Annual Preventative Dental Visits*	*High Confidence*	*Moderate Confidence*	100%	0%	0%	50%	50%	0%
MCNA	*Increase the Percentage of Dental Services*	*High Confidence*	*High Confidence*	100%	0%	0%	100%	0%	0%

Validation Rating 1—Overall confidence of adherence to acceptable methodology for all phases of the PIP.
Validation Rating 2—Overall confidence that the PIP achieved significant improvement.

Performance Measure Validation

Table 7-2 displays the MLTSS MY 2024 rates for the MCOs and the statewide weighted averages.

Table 7-2—MLTSS MCO Performance Measure Comparison and Statewide Aggregate Rates

Performance Measure		Measure Rates			
		ITC	MOL	WLP	Statewide Aggregate
Medicaid MLTSS Admission to a Facility from the Community (MLTSS-6)					
1.	*Short-Term Stay—18–64 Years*	0.92	94.52	2.72	7.03
	Short-Term Stay—65–74 Years	3.59	495.96	2.23	5.91
	Short-Term Stay—75–84 Years	3.98	NA	1.24	6.19
	Short-Term Stay—85+ Years	3.19	NA	0.65	1.97
	Medium-Term Stay—18–64 Years	1.70	23.11	0.79	2.33
	Medium-Term Stay—65–74 Years	6.39	94.34	2.54	4.56
	Medium-Term Stay—75–84 Years	8.17	NA	1.84	4.59
	Medium-Term Stay—85+ Years	8.30	NA	1.25	3.67
	Long-Term Stay—18–64 Years	4.37	17.30	0.15	2.64
	Long-Term Stay—65–74 Years	13.72	32.35	0.61	5.69
	Long-Term Stay—75–84 Years	20.03	NA	0.36	7.81
	Long-Term Stay—85+ Years	34.48	NA	0.76	11.11
Medicaid MLTSS Minimizing Facility Length of Stay (MLTSS-7)					
2.	*Observed Rate*	13.10%	13.21%	47.83%	20.06%
	Risk-Adjusted Rate	23.32%	24.48%	33.44%	25.74%
	O/E Ratio	0.5616	0.5395	1.4303	0.7794
Medicaid MLTSS Successful Transition After Long-Term Facility Stay (MLTSS-8)					
3.	*Observed Rate*	13.77%	5.17%	55.88%	21.67%
	Risk-Adjusted Rate	59.55%	46.59%	69.85%	59.73%
	O/E Ratio	0.2313	0.1110	0.8001	0.3627

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

Table 7-3 shows the aggregate CMS Core Set performance measure rates and measure designations for all Medicaid populations, including Fee-for-Service (FFS), as calculated by the HHS vendor, IBM.

Table 7-3—CMS Core Set Performance Measure Rates

	Performance Measure	Abbreviation	Statewide Aggregate Measure Rate
1.	*Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—3 Months–17 Years*	*AAB*	70.98%
2.	*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*	*ADD-E*	55.13%
	Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase		62.53%
3.	*Antidepressant Medication Management—Effective Acute Phase Treatment—18–64 Years*	*AMM*	54.26%
	Antidepressant Medication Management—Effective Acute Phase Treatment—65+ Years		NA
	Antidepressant Medication Management—Effective Continuation Phase Treatment—18–64 Years		31.80%
	Antidepressant Medication Management—Effective Continuation Phase Treatment—65+ Years		NA
4.	*Asthma Medication Ratio—5–18 Years*	*AMR*	74.30%
5.	*Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*	*APM-E*	48.43%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total		26.42%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total		25.38%
6.	*Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*	*APP*	62.70%
7.	*Screening for Depression and Follow-Up Plan—12–17 Years*	*CDF*	0.68%
	Screening for Depression and Follow-Up Plan—18–64 Years		1.54%
	Screening for Depression and Follow-Up Plan—65+ Years		1.79%
8.	*Chlamydia Screening in Women—16–20 Years*	*CHL*	33.59%

	Performance Measure	Abbreviation	Statewide Aggregate Measure Rate
9.	*Childhood Immunization Status—Combination 3*	*CIS-E*	37.50%
	Childhood Immunization Status—Combination 7		32.50%
	Childhood Immunization Status—Combination 10		14.06%
10.	*Developmental Screening in the First Three Years of Life—Total*	*DEV*	40.40%
11.	*Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—13–17 Years*	*FUA*	38.86%
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—13–17 Years		52.33%
	Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—18–64 Years		39.57%
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—18–64 Years		54.13%
	Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—65+ Years		NA
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—65+ Years		NA
12.	*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years*	*FUH*	49.14%
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years		73.12%
	Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years		38.47%
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years		59.61%
	Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years		NA
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years		NA

	Performance Measure	Abbreviation	Statewide Aggregate Measure Rate
13.	*Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—6–17 Years*	*FUM*	51.57%
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—6–17 Years		75.05%
	Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—18–64 Years		37.40%
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—18–64 Years		55.53%
	Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—65+ Years		NA
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—65+ Years		NA
14.	*Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control >9.0%—18–64 Years**	*HPCMI*	79.82%
	*Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control >9.0%—65–75 Years**		NA
15.	*Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—18–64 Years*	*IET*	38.93%
	Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—65+ Years		NA
	Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total—18–64 Years		15.52%
	Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total—65+ Years		NA
16.	*Immunizations for Adolescents—Combination 1*	*IMA-E*	61.65%
	Immunizations for Adolescents—Combination 2		20.38%
17.	*Lead Screening in Children*	*LSC*	75.23%
18.	*Oral Evaluation, Dental Services—Total*	*OEV*	46.55%

	Performance Measure	Abbreviation	Statewide Aggregate Measure Rate
19.	*Use of Pharmacotherapy for Opioid Use Disorder—Rate 1: Total*	*OUD*	64.28%
20.	*Sealant Receipt on Permanent First Molars—At Least One Sealant*	*SFM*	38.49%
	Sealant Receipt on Permanent First Molars—All Four Molars Sealed		32.46%
21.	*Topical Fluoride for Children—Dental or Oral Health Services—Total*	*TFL*	23.78%
	Topical Fluoride for Children—Dental Services—Total		22.78%
	Topical Fluoride for Children—Oral Health Services—Total		0.40%
22.	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia*	*SAA*	74.48%
23.	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	*SSD*	79.91%
24.	*Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*	*W30*	70.51%
	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		76.00%
25.	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile—Total*	*WCC*	27.48%
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total		10.42%
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total		7.46%
26.	*Child and Adolescent Well-Care Visits—Total*	*WCV*	62.49%

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

Table 7-4 displays CMS Core Set performance measure rates and measure designations for **ITC, MOL**, and **WLP**, as calculated by the HHS vendor, IBM.

Table 7-4—Core Set MY 2024 Rates—MCO Comparison

	Performance Measure	Abbreviation	ITC	MOL	WLP
1.	*Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—3 Months–17 Years*	*AAB*	72.63%	72.82%	69.18%
2.	*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*	*ADD-E*	56.80%	50.00%	55.84%
	Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase		62.66%	NA	64.37%
3.	*Antidepressant Medication Management—Effective Acute Phase Treatment—18–64 Years*	*AMM*	53.39%	57.84%	55.29%
	Antidepressant Medication Management—Effective Acute Phase Treatment—65+ Years		NA	NA	NA
	Antidepressant Medication Management—Effective Continuation Phase Treatment—18–64 Years		30.18%	37.81%	33.01%
	Antidepressant Medication Management—Effective Continuation Phase Treatment—65+ Years		NA	NA	NA
4.	*Asthma Medication Ratio—5–18 Years*	*AMR*	73.01%	76.28%	75.20%
5.	*Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*	*APM-E*	43.48%	41.70%	47.20%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total		23.91%	18.92%	26.20%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total		21.74%	18.15%	24.80%
6.	*Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*	*APP*	63.18%	58.15%	66.01%

	Performance Measure	Abbreviation	ITC	MOL	WLP
7.	*Screening for Depression and Follow-Up Plan—12–17 Years*	*CDF*	0.42%	1.33%	0.44%
	Screening for Depression and Follow-Up Plan—18–64 Years		0.72%	3.69%	0.59%
	Screening for Depression and Follow-Up Plan—65+ Years		0.00%	4.03%	0.00%
8.	*Chlamydia Screening in Women—16–20 Years*	*CHL*	28.44%	31.14%	27.98%
9.	*Childhood Immunization Status—Combination 3*	*CIS-E*	37.00%	39.38%	37.08%
	Childhood Immunization Status—Combination 7		33.23%	34.71%	32.77%
	Childhood Immunization Status—Combination 10		15.12%	15.27%	14.51%
10.	*Developmental Screening in the First Three Years of Life—Total*	*DEV*	40.07%	39.13%	40.59%
11.	*Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—13–17 Years*	*FUA*	45.90%	46.00%	30.56%
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—13–17 Years		55.74%	56.00%	47.22%
	Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—18–64 Years		40.99%	39.04%	39.86%
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—18–64 Years		55.63%	53.39%	55.29%
	Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—65+ Years		NA	NA	NA
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—65+ Years		NA	NA	NA

	Performance Measure	Abbreviation	ITC	MOL	WLP
12.	*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years*	*FUH*	46.65%	46.23%	54.34%
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years		71.18%	72.48%	76.18%
	Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years		38.66%	37.21%	43.22%
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years		60.59%	56.23%	65.57%
	Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years		NA	NA	NA
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years		NA	NA	NA
13.	*Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—6–17 Years*	*FUM*	51.05%	49.36%	53.96%
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—6–17 Years		75.95%	71.66%	76.56%
	Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—18–64 Years		38.61%	33.94%	39.87%
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—18–64 Years		58.13%	49.92%	58.61%
	Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—65+ Years		NA	NA	NA
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—65+ Years		NA	NA	NA
14.	*Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control >9.0%—18–64 Years**	*HPCMI*	77.78%	83.02%	80.77%
	*Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control >9.0%—65–75 Years**		NA	NA	NA

	Performance Measure	Abbreviation	ITC	MOL	WLP
15.	*Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—18–64 Years*	*IET*	38.24%	41.15%	38.50%
	Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—65+ Years		NA	NA	NA
	Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total—18–64 Years		15.26%	17.01%	15.03%
	Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total—65+ Years		NA	NA	NA
16.	*Immunizations for Adolescents—Combination 1*	*IMA-E*	61.21%	61.25%	64.48%
	Immunizations for Adolescents—Combination 2		19.61%	18.71%	21.17%
17.	*Lead Screening in Children*	*LSC*	74.81%	76.70%	75.99%
18.	*Use of Pharmacotherapy for Opioid Use Disorder—Rate 1: Total*	*OUD*	62.35%	65.46%	67.08%
19.	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia*	*SAA*	76.19%	69.46%	79.26%
20.	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	*SSD*	80.00%	78.46%	82.79%
21.	*Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*	*W30*	72.60%	69.80%	71.89%
	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		77.50%	76.19%	76.67%

	Performance Measure	Abbreviation	ITC	MOL	WLP
22.	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile—Total*	*WCC*	30.41%	20.18%	29.55%
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total		9.71%	10.17%	10.70%
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total		7.31%	8.13%	6.96%
23.	*Child and Adolescent Well-Care Visits—Total*	*WCV*	65.01%	61.40%	63.95%

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

Table 7-5 displays the HEDIS MY 2024 rates for **ITC**, **MOL**, and **WLP** and the statewide weighted averages.

Table 7-5—HEDIS MY 2024 Rates—MCO Comparison

Measures	Iowa Total Care HEDIS MY 2024 Rate	Molina HEDIS MY 2024 Rate	WellPoint HEDIS MY 2024 Rate	Statewide HEDIS MY 2024 Weighted Averages
Access to Preventive Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	80.97% ★★★★	77.24% ★★★	81.24% ★★★★	80.13% ★★★
45–64 Years	86.57% ★★★	81.13% ★★	87.16% ★★★★	85.54% ★★★
65+ Years	83.88% ★★★	85.45% ★★★	96.06% ★★★★★	90.04% ★★★
Use of Imaging Studies for Low Back Pain				
Total	65.11% ★	64.83% ★	66.14% ★★	65.47% ★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI percentile—Total	84.67% ★★★	66.42% ★	80.54% ★★	78.21% ★★
Counseling for Nutrition—Total	69.34% ★★	55.72% ★	61.56% ★	62.60% ★
Counseling for Physical Activity—Total	63.02% ★★	51.09% ★	57.91% ★	57.81% ★
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	56.57% ★★★	NA NC	57.72% ★★★	57.26% ★★★
Cervical Cancer Screening				
Cervical Cancer Screening	55.50% ★★★	45.04% ★	56.53% ★★★	53.34% ★★★
Chlamydia Screening in Women				
Total	44.21% ★	45.71% ★	43.95% ★	44.45% ★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	89.78% ★★★★	80.54% ★	83.70% ★★	84.90% ★★

Measures	Iowa Total Care HEDIS MY 2024 Rate	Molina HEDIS MY 2024 Rate	WellPoint HEDIS MY 2024 Rate	Statewide HEDIS MY 2024 Weighted Averages
Postpartum Care	86.62% ★★★★	80.54% ★★	83.21% ★★★	83.65% ★★★
Living With Illness				
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%	63.50% ★★★	54.01% ★	64.48% ★★★	62.03% ★★★
*Glycemic Status >9.0%**	28.47% ★★★	36.74% ★	28.47% ★★★	30.15% ★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	79.32% ★★★★★	72.75% ★★★	77.86% ★★★★	77.31% ★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	62.29% ★★★	51.82% ★★	61.07% ★★★	59.60% ★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	75.67% ★★★★★	63.50% ★	73.24% ★★★★	72.06% ★★★★
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	80.04% ★★	NA NC	81.74% ★★★	81.01% ★★
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	63.26% ★★	NA NC	67.18% ★★★	65.54% ★★
Behavioral Health				
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	70.94% ★★	64.19% ★	76.34% ★★★	72.79% ★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.36% ★★★	79.76% ★	83.29% ★★★	82.57% ★★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Total	41.16% ★★★★★	39.71% ★★★★★	37.89% ★★★★	39.51% ★★★★★
30-Day Follow-Up—Total	54.90% ★★★★★	53.91% ★★★★★	51.09% ★★★★	53.19% ★★★★

Measures	Iowa Total Care HEDIS MY 2024 Rate	Molina HEDIS MY 2024 Rate	WellPoint HEDIS MY 2024 Rate	Statewide HEDIS MY 2024 Weighted Averages
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total	62.06% ★★★★★	57.10% ★★★★	63.61% ★★★★★	61.43% ★★★★
30-Day Follow-Up—Total	75.47% ★★★★★	70.32% ★★★★	78.00% ★★★★★	75.21% ★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	67.09% ★★★★★	40.19% ★★★	68.08% ★★★★★	60.08% ★★★★★
30-Day Follow-Up—Total	80.94% ★★★★★	62.08% ★★★	82.71% ★★★★★	76.47% ★★★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—Total	54.18% ★★★★	53.97% ★★★★	49.74% ★★★	52.26% ★★★★
Engagement of SUD Treatment—Total—Total	20.11% ★★★★	17.68% ★★★	19.13% ★★★	19.16% ★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total	26.70% ★	25.53% ★	29.40% ★	27.81% ★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	64.47% ★★★	60.24% ★★	65.33% ★★★	63.87% ★★★
Keeping Kids Healthy				
Childhood Immunization Status				
Combination 3	74.21% ★★★★	68.59% ★★★	75.91% ★★★★★	73.80% ★★★★
Combination 10	36.98% ★★★★	30.37% ★★★	33.09% ★★★	34.23% ★★★★
Immunizations for Adolescents				
Combination 1	90.27% ★★★★★	82.00% ★★★	88.08% ★★★★	87.79% ★★★★
Combination 2	33.58% ★★	33.58% ★★	30.41% ★	32.13% ★★
Lead Screening in Children				
Lead Screening in Children	79.15% ★★★★	80.78% ★★★★	83.21% ★★★★★	81.02% ★★★★

Measures	Iowa Total Care HEDIS MY 2024 Rate	Molina HEDIS MY 2024 Rate	WellPoint HEDIS MY 2024 Rate	Statewide HEDIS MY 2024 Weighted Averages
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	69.87% ★★★★	66.17% ★★★	67.41% ★★★	68.47% ★★★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	75.56% ★★★	74.08% ★★★	75.69% ★★★	75.45% ★★★
Child and Adolescent Well-Care Visits				
Total	58.65% ★★★	56.52% ★★★	57.93% ★★★	57.80% ★★★
Medication Management				
Statin Therapy for Patients With Cardiovascular Disease				
Statin Adherence 80%—Total	65.45% ★	NA NC	73.06% ★★★	69.82% ★★
Statin Therapy for Patients With Diabetes				
Statin Adherence 80%	64.70% ★★	NA NC	69.82% ★★★	67.75% ★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.81% ★★	61.74% ★★	72.76% ★★★★	68.44% ★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	56.26% ★	55.90% ★	58.78% ★★	57.39% ★
Effective Continuation Phase Treatment	40.03% ★	39.72% ★	42.68% ★★	41.23% ★★
Appropriate Testing for Pharyngitis				
Total	87.45% ★★★	88.44% ★★★	87.71% ★★★	87.80% ★★★
Asthma Medication Ratio				
Total	64.90% ★★★	NA NC	64.47% ★★★	64.63% ★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Total	57.00% ★★	55.47% ★★	54.51% ★★	55.62% ★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	54.70% ★★★★	52.11% ★★★★	48.74% ★★★	51.27% ★★★★

Measures	Iowa Total Care HEDIS MY 2024 Rate	Molina HEDIS MY 2024 Rate	WellPoint HEDIS MY 2024 Rate	Statewide HEDIS MY 2024 Weighted Averages
Continuation and Maintenance Phase	62.52% ★★★★	48.70% ★	53.75% ★★	56.61% ★★★
Appropriate Treatment for Upper Respiratory Infection				
Total	88.72% ★★	88.93% ★★★	87.93% ★★	88.43% ★★
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	49.06% ★	48.15% ★	57.41% ★★★	51.55% ★★
Pharmacotherapy Management of COPD Exacerbation				
Bronchodilator	77.97% ★	80.07% ★★	80.51% ★★	79.56% ★★
Systemic Corticosteroid	69.59% ★★	75.95% ★★★	72.12% ★★★	72.00% ★★★
Use of Opioids at High Dosage*				
Use of Opioids at High Dosage	1.27% ★★★★	1.04% ★★★★	2.81% ★★★	1.98% ★★★
Use of Opioids From Multiple Providers*				
Multiple Pharmacies	2.62% ★★	2.29% ★★★	1.93% ★★★	2.22% ★★★
Multiple Prescribers	18.89% ★★★	19.54% ★★	18.60% ★★★	18.88% ★★★
Multiple Prescribers and Multiple Pharmacies	1.81% ★★	1.74% ★★	1.53% ★★★	1.66% ★★

* For this indicator, a lower rate indicates better performance.
"NC" indicates the rate could not be compared to the national Medicaid MY 2024 benchmarks.
"NA" indicates that the denominator was too small to calculate a rate; therefore, a rate is not displayed.
HEDIS MY 2024 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★ = At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Table 7-6 displays the DWP Adult rates for each PAHP and the statewide aggregate rate, and Table 7-7 displays the DWP Kids rates for each PAHP and the statewide aggregate rate. No rate comparison is provided for the Hawki population since **DDIA** is the only PAHP that oversees this member population.

Table 7-6—SFY 2025 Performance Measure Rates for DWP Adults—PAHP Comparison

Performance Measure		Measure Rates—DWP Adults		
		DDIA	MCNA	Statewide Aggregate
Performance Measure 2	*Access to Dental Services*	27.60%	18.33%	24.35%
Performance Measure 3	*Access to Preventative Dental Services*	95.01%	94.73%	94.94%

Table 7-7—SFY 2025 Performance Measure Rates for DWP Kids—PAHP Comparison

Performance Measure		Measure Rates—DWP Kids		
		DDIA	MCNA	Statewide Aggregate
Performance Measure 2	*Access to Dental Services*	55.14%	45.55%	51.82%
Performance Measure 3	*Access to Preventative Dental Services*	97.84%	98.77%	98.12%

Compliance Review

HSAG calculated the Iowa Managed Care Program's performance in each of the 14 compliance review standards that were reviewed during the first two years of the three-year compliance review cycle (CY 2024 through CY 2026). Table 7-8 compares the MCPs' compliance scores and the Iowa Managed Care Program aggregated score in each of the 14 compliance review standards.

Table 7-8—MCP and Iowa Managed Care Program Compliance Review Scores for CY 2024 and CY 2025

Standard	ITC	MOL	WLP	DDIA	MCNA	Iowa Managed Care Program
Standard I—Disenrollment: Requirements and Limitations	100%	86%	100%	100%	100%	**97%**
Standard II—Member Rights and Member Information	88%	79%	79%	85%	85%	**83%**
Standard III—Emergency and Poststabilization Services	100%	100%	100%	100%	100%	**100%**
Standard IV—Availability of Services	94%	94%	94%	100%	100%	**96%**
Standard V—Assurances of Adequate Capacity and Services	100%	100%	100%	100%	100%	**100%**
Standard VI—Coordination and Continuity of Care	83%	89%	78%	88%	88%	**84%**
Standard VII—Coverage and Authorization of Services	93%	88%	90%	90%	81%	**89%**
Total Compliance Score of Year One (CY 2024)	**93%**	**90%**	**90%**	**93%**	**90%**	**91%**
Standard VIII—Provider Selection	95%	95%	80%	94%	94%	**92%**
Standard IX—Confidentiality	95%	100%	86%	100%	95%	**95%**
Standard X—Grievance and Appeal Systems	92%	82%	84%	89%	84%	**86%**
Standard XI—Subcontractual Relationships and Delegation	86%	100%	71%	100%	86%	**89%**
Standard XII—Practice Guidelines	100%	100%	100%	100%	100%	**100%**
Standard XIII—Health Information Systems	89%	100%	89%	89%	78%	**89%**
Standard XIV—Quality Assessment and Performance Improvement Program	100%	100%	100%	92%	83%	**96%**
Total Compliance Score for Year Two (SFY 2025)	**94%**	**93%**	**87%**	**94%**	**88%**	**91%**
Combined Compliance Score for Year One (SFY 2024) and Year Two (SFY 2025)	**93%**	**91%**	**88%**	**93%**	**89%**	**91%**

Network Adequacy Validation

Time and distance indicators reflected widespread access among members across almost all provider types. However, HSAG noted that for two provider types, there was a notable difference between **MOL** and the remaining MCOs for reported percentage of member access. Table 7-9 lists these provider types and the member access reported by **MOL**, compared to access reported by **ITC** and **WLP**.

Table 7-9—MCO Member Access Disparity Comparison by Provider Type and Urbanicity

Provider Type	Urbanicity	MOL Member Access Percent	Other Plans and Percent of Member Access
Dermatology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	64.5%	**ITC**, **WLP** (100%)
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	82.6%	**ITC**, **WLP** (100%)
Ophthalmology—Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	0%	**ITC**, **WLP** (100%)
	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	0%	**ITC**, **WLP** (100%)

For Appointment Wait Time indicators, results were to be submitted by the MCOs for any surveys conducted between the end of 2024 and June 30, 2025. **ITC** did not complete a survey during that time frame. **MOL** and **WLP** conducted surveys and submitted results. HSAG reviewed the surveys for alignment with HHS requirements, and a summary of findings are displayed in Table 7-10.

Table 7-10—MCO Appointment Wait Time Survey Summary Assessments

MCO	Summary
ITC	**ITC** did not conduct a survey for the period in scope of review.
MOL	**MOL** conducted a revealed caller survey and used statistically valid sampling methods to identify providers included in the sample. The survey aligned with all HHS indicators.
WLP	**WLP** contracted with a third-party vendor to conduct the survey using a standardized script and randomized sampling method to identify providers included in the sample. The survey aligned with eight of the 12 HHS indicators.

Time and distance indicators reflected widespread access among members across the provider types of General Dentist, Pediatric Dentist, Oral Surgeon, and Orthodontist. However, as noted in Table 7-11, access for a large percentage of members, especially within 60 minutes or 60 miles for the three provider types of Periodontist, Prosthodontist, and Endodontist, was much more limited across both Dental PAHPs.

Table 7-11—PAHP Provider Types with Limited Member Access

Provider Type	Urbanicity	DDIA Member Access Percent	MCNA Member Access Percent
Periodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	57.00%	40.10%
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	82.60%	72.70%
Prosthodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	21.90%	33.70%
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	40.50%	61.00%
Endodontist	60 minutes or 60 miles from the DWP enrollee place of residence for at least 75% of Enrolled Members	45.60%	40.40%
	90 minutes or 90 miles from the DWP enrollee place of residence for ALL Enrolled Members	65.10%	62.90%

HSAG reviewed reported appointment wait time results provided by the dental PAHPs for alignment with HHS requirements, and a summary of findings are displayed in Table 7-12.

Table 7-12—PAHP Appointment Wait Time Survey Summary Assessments

PAHP	Summary
DDIA	**DDIA** collected the next available wait time for providers by requiring providers to report the next available appointment time as part of a mandatory quarterly attestation on the provider portal. This information was then reported on the HHS B11 reporting template. **DDIA** did not conduct a separate appointment wait time survey that aligned with HHS appointment wait time indicators.
MCNA	**MCNA** obtained average appointment wait time via in-office visits with general and specialist dentists. **MCNA** also asked if appointments were available within six to eight weeks, within 24 hours, and within 48 hours. **MCNA** did not capture data for the availability of specialist dentist appointments "within 30 days for routine care" as required by HHS appointment wait time indicators.

Encounter Data Validation

Medical Record Review—MCO

Table 7-13 shows the medical record procurement status for each of the participating MCOs, detailing the number of medical records requested, the number and percentage of medical records submitted, and the number and percentage of records reviewed. HSAG did not review submitted records if they were not valid. Examples of invalid submissions include documentation that was for services without supporting clinical documentation (e.g., lab results), an order rather than a medical record, a billing summary, or cases where the tracking sheet indicated a record was submitted but HSAG did not receive the record.

Table 7-13—Medical Record Procurement Status: Requested Sample Date of Service

MCO	Number of Medical Records Requested	Submitted Records		Reviewed Records	
		Number	Percent	Number	Percent
ITC	411	390	94.9%	390	100%
MOL	411	353	85.9%	353	100%
WLP	411	368	89.5%	368	100%
All MCOs	**1,233**	**1,111**	**90.1%**	**1,111**	**100%**

Table 7-14 displays the number and percentage of submitted and reviewed medical records for which the provider selected and submitted an additional date of service for the study. HSAG did not review submitted records if they were not valid. Reasons for invalid records included instances in which the servicing provider did not have the same NPI as the sampled record; the place of service or provider type did not align with the sampling criteria; the submitted date of service was not within the study period; or the tracking sheet indicated a record was submitted but HSAG did not receive the record. In most instances, for example cases where the tracking sheet indicated submission, but the record was not received, HSAG documented the case on a procurement issue list and provided it to the MCOs for follow-up and resolution after the procurement period.

Table 7-14—Medical Record Submission Status: Second Date of Service (if available)

MCO	Submitted Records		Reviewed Records	
	Number	Percent	Number	Percent
ITC	200	48.7%	193	96.5%
MOL	103	25.1%	86	83.5%
WLP	204	49.6%	169	82.8%
All MCOs	**507**	**41.1%**	**448**	**88.4%**

Table 7-15 displays the medical record and encounter data omission rates for each key data element. **For the medical record omission and encounter data omission indicators, lower rates indicate better performance.**

Table 7-15—Encounter Data Completeness Summary

	Medical Record Omission				Encounter Data Omission			
Key Data Element	Overall Rate	ITC Rate	MOL Rate	WLP Rate	Overall Rate	ITC Rate	MOL Rate	WLP Rate
Date of Service	**7.3%**	3.5%	11.8%	7.5%	**1.0%**	1.0%	1.4%	0.7%
Diagnosis Code	**9.0%**	5.7%	12.8%	9.1%	**0.8%**	0.7%	0.9%	0.7%
Procedure Code	**11.1%**	8.3%	17.4%	8.5%	**3.5%**	3.1%	2.9%	4.4%
Procedure Code Modifier(s)	**15.2%**	10.5%	25.3%	12.6%	**2.2%**	3.3%	1.0%	1.7%

Table 7-16 displays dates of service present in both HHS' encounter data and in the medical records with the same values for all key data elements in Table A-16 and the all-element accuracy rates. **For this indicator, higher rates indicate better performance.**

Table 7-16—Encounter Data Accuracy Summary

Key Data Element	Overall Rate	ITC Rate	MOL Rate	WLP Rate
Diagnosis Code	**99.3%**	99.2%	99.0%	99.6%
Procedure Code	**98.5%**	98.7%	98.8%	98.1%
Procedure Code Modifier(s)	**99.9%**	100%	99.5%	100%
All-Element Accuracy[1]	**82.4%**	82.5%	81.5%	82.9%

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

Comparative Analysis—MCO

For CY 2025, HSAG conducted a comparative analysis exclusively for **MOL**. In the prior year, the comparative analysis for **MOL** was limited to four months of data because **MOL** began serving the Iowa Medicaid managed care members on July 1, 2023. **ITC** and **WLP** previously underwent comparative analyses in consecutive years (CY 2022, CY 2023, and CY 2024). Given that the CY 2025 comparative analysis was conducted only for **MOL**, no comparative analysis findings are reported in this section. For detailed **MOL** performance results, please refer to the "External Quality Review Activity Results" for **MOL** in Section 3.

Comparative Analysis—PAHP

Table 7-17 displays the percentage of record omission and the percentage of record surplus. Lower rates indicate better performance for both record omission and record surplus.

Table 7-17—Record Omission and Surplus: Dental Encounters

PAHP	Record Omission	Record Surplus
DDIA	0.2%	0.2%
MCNA	3.6%	1.7%
Overall	**1.0%**	**0.6%**

Table 7-18 displays the overall rates of element omission, element surplus, and element missing values for each key data element from the dental encounters. Additionally, Table 7-18 displays the overall accuracy rate for each key data element among records that could be matched between the PAHP-submitted files and the HHS-submitted files. For the element omission and surplus indicators, lower rates indicate better performance, whereas, for element accuracy, higher rates indicate better performance.

Missing value rates are presented for context only, as lower or higher rates do not necessarily reflect better or worse performance due to varying reporting requirements across data elements.

Table 7-18—Overall Data Element Omission, Surplus, Missing Values, and Accuracy: Dental Encounters

Key Data Element	Element Omission	Element Surplus	Element Missing Values	Element Accuracy
Member ID	0.0%	<0.1%	0.0%	>99.9%
Detail Service From Date	0.0%	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	99.9%
Header Service To Date	0.0%	0.0%	0.0%	99.7%
Billing Provider NPI	0.0%	<0.1%	0.0%	98.4%
Rendering Provider NPI	0.0%	<0.1%	0.0%	49.2%
CDT Code	0.0%	0.0%	0.0%	98.7%
Units of Service	0.0%	0.0%	0.0%	>99.9%
Tooth Number	1.1%	0.2%	73.9%	98.5%
Tooth Surface 1–5[1]	0.1%	0.1%	91.0%	99.7%
Oral Cavity Code 1–5[2]	<0.1%	<0.1%	98.9%	99.4%
Header Paid Amount	0.0%	0.0%	0.0%	70.0%
Detail Paid Amount	0.0%	<0.1%	0.0%	92.6%

[1] All submitted tooth surface codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted oral cavity codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table 7-19 displays summary results showing the number of key data elements with low element omission or surplus rates (i.e., below 5.0 percent) as well as high element accuracy rates (i.e., above 95.0 percent). The table also presents the all-element accuracy results, which represent the percentage of records present in both data sources that contained the same values (missing or non-missing) across all key data elements.

Table 7-19—Element Omission, Surplus, and All-Element Accuracy: Dental Encounters

PAHP	Number of Key Data Elements With Element Omission ≤ 5.0 Percent (N=14)[1]	Number of Key Data Elements With Element Surplus Rates ≤ 5.0 Percent (N=14)[1]	Number of Key Data Elements With Element Accuracy ≥ 95.0 Percent (N=14)[2]	All-Element Accuracy[3]
DDIA	14	14	11	28.8%
MCNA	14	14	11	9.8%

[1] N indicates the number of key data elements included in the completeness calculations.
[2] N indicates the number of key data elements included in the accuracy calculations.
[3] Indicates the percentage of matched records that contained the same values (missing or non-missing) across all key data elements.

Table 7-20 displays the overall encounter accuracy rates by PAHP. All results are presented based on the number of encounters in the primary file with higher match rates, indicating better performance.

Table 7-20—Overall Encounter Accuracy: Dental Encounters

PAHP	HHS to PAHP			PAHP to HHS		
	Match	Partial Match	No Match	Match	Partial Match	No Match
DDIA	28.9%	70.9%	0.2%	28.9%	70.9%	0.2%
MCNA	10.5%	89.3%	0.2%	10.1%	89.8%	0.1%
Overall	**24.7%**	**75.1%**	**0.2%**	**24.6%**	**75.2%**	**0.2%**

Note: The sum of Match, Partial Match, and No Match rates may not equal 100 percent due to rounding.

Consumer Assessment of Healthcare Providers and Systems Analysis

HSAG compared each MCO's and the MCO program's (i.e., **ITC**, **WLP**, and **MOL** combined) results to the 2024 NCQA national averages to determine if the results were statistically significantly higher or lower than the 2024 NCQA national averages. Arrows in the tables note statistical significance.

Table 7-21 and Table 7-22 present the 2025 top-box scores for **ITC**, **WLP**, and **MOL** compared to the top-box scores of the MCO program for the adult and child Medicaid populations, respectively.

Table 7-21—2025 MCO Adult CAHPS Comparisons

	ITC	WLP	MOL	MCO Program
Composite Measures				
Getting Needed Care	87.57% ↑	86.75% ↑	83.96%	86.43% ↑
Getting Care Quickly	88.78% ↑	83.94%	81.60%	85.64% ↑
How Well Doctors Communicate	94.56%	97.45% ↑	94.20%	95.32% ↑
Customer Service	93.19% ↑	86.67%	NA	89.50%
Global Ratings				
Rating of All Health Care	52.03%	54.38%	53.16%	53.00% ↓
Rating of Personal Doctor	72.79%	70.50%	68.25%	71.02%
Rating of Specialist Seen Most Often	60.75% ↓	58.45% ↓	67.54%	61.70% ↓
Rating of Health Plan	60.34%	58.06%	54.75% ↓	58.26% ↓
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
Advising Smokers and Tobacco Users to Quit	69.42%	75.74%	NA	72.95%
Discussing Cessation Medications	50.91%	44.97% ↓	NA	49.53%
Discussing Cessation Strategies	46.21%	43.20%	NA	44.57%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as "NA" (i.e., Not Applicable).
* These scores follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2025 score is statistically significantly higher than the 2024 national average.
↓ Indicates the 2025 score is statistically significantly lower than the 2024 national average.

Table 7-22—2025 MCO Child CAHPS Comparisons

	ITC	WLP	MOL	MCO Program
Composite Measures				
Getting Needed Care	88.27% ↑	90.59% ↑	87.06%	88.80% ↑
Getting Care Quickly	90.23% ↑	92.62% ↑	92.08% ↑	91.47% ↑

	ITC	WLP	MOL	MCO Program
How Well Doctors Communicate	96.38% ↑	96.09% ↑	94.99%	95.96% ↑
Customer Service	89.95%	NA	NA	89.96%
Global Ratings				
Rating of All Health Care	67.85%	68.79%	72.60%	69.30%
Rating of Personal Doctor	80.54% ↑	77.60%	80.33%	79.55% ↑
Rating of Specialist Seen Most Often	73.33%	74.77%	NA	73.13%
Rating of Health Plan	71.83%	64.50% ↓	64.90% ↓	67.79% ↓

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as "NA" (i.e., Not Applicable).
↑ Indicates the 2025 score is statistically significantly higher than the 2024 national average.
↓ Indicates the 2025 score is statistically significantly lower than the 2024 national average.

Table 7-23 presents the 2025 top-box scores for **WLP** and **MOL** compared to the top-box scores of the MCO program for the CCC Medicaid population.

Table 7-23—2025 MCO CCC CAHPS Comparisons

	WLP	MOL	MCO Program
Composite Measures			
Getting Needed Care	87.54% ↑	82.43%	86.18% ↑
Getting Care Quickly	91.43% ↑	92.55% ↑	91.74% ↑
How Well Doctors Communicate	96.00% ↑	94.51%	95.56% ↑
Customer Service	84.91%	NA	88.10%
Global Ratings			
Rating of All Health Care	63.78%	62.16%	63.33%
Rating of Personal Doctor	78.69%	80.32%	79.19% ↑
Rating of Specialist Seen Most Often	76.68%	NA	76.17%
Rating of Health Plan	60.49% ↓	59.20% ↓	60.09% ↓
CCC Composite Measures/Items			
Access to Specialized Services	75.67%	NA	75.42%
Family Centered Care (FCC): Personal Doctor Who Knows Child	91.29%	90.69%	91.13%
Coordination of Care for Children With Chronic Conditions	75.13%	NA	75.51%
Access to Prescription Medicines	92.37% ↑	92.41%	92.38% ↑

	WLP	MOL	MCO Program
FCC: Getting Needed Information	92.41%	95.92% ↑	93.38% ↑

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as "NA" (i.e., Not Applicable).
↑ Indicates the 2025 score is statistically significantly higher than the 2024 national average.
↓ Indicates the 2025 score is statistically significantly lower than the 2024 national average.

Scorecard

HHS contracted with HSAG in CY 2025 to develop a scorecard to evaluate the performance of Iowa Medicaid MCOs. The Iowa Medicaid scorecard demonstrates how the MCOs compare to 2025 NCQA Quality Compass national Medicaid health maintenance organization (HMO) benchmarks in key performance areas. The tool uses stars to display results for the MCOs, as shown Table 7-24. Please refer to Appendix A for the detailed methodology used for this tool.

Table 7-24—Iowa Medicaid Scorecard Results—MCO Scorecard Performance Ratings

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

Table 7-25 displays the 2025 Iowa Medicaid Scorecard results for each MCO.

Table 7-25—2025 Iowa Medicaid Scorecard Results

MCO	Doctors' Communication and Patient Engagement	Access to Preventive Care	Women's Health	Living With Illness	Behavioral Health	Medication Management
ITC	★★★	★★★★	★★★	★★★	★★★	★★★
MOL	★★★	★★★	★★	★★	★★★	★★★★
WLP	★★★	★★★★	★★★	★★★	★★★★	★★★★

For 2025, **WLP** demonstrated the strongest performance by achieving High Performance for three of the six reporting categories (*Access to Preventive Care*, *Behavioral Health*, and *Medication Management*) and Average Performance for three of the six reporting categories (*Doctors' Communication and Patient Engagement*, *Women's Health*, and *Living With Illness*). **ITC** demonstrated Average Performance by achieving High Performance for one of the six reporting categories (*Access to Preventive Care*) and Average Performance for five of the six reporting categories (*Doctors' Communication and Patient Engagement*, *Women's Health*, *Living With Illness*, *Behavioral Health*, and *Medication Management*). **MOL** demonstrated Low Performance by achieving High Performance for one of the six reporting categories (*Medication Management*), Average Performance for three of the six reporting categories (*Doctors' Communication and Patient Engagement*, *Access to Preventive Care*, and *Behavioral Health*), and Low Performance for two of the six reporting categories (*Women's Health* and *Living With Illness*). Opportunities for improvement exist, with all three MCOs having Average Performance in at least three of the reporting categories.

8. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the MCPs' performance and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the Iowa Managed Care Program to identify programwide conclusions. The programwide conclusions are not intended to be inclusive of all EQR activity results; rather, only those results that had a substantial impact on an Iowa HHS Medicaid Quality Strategy strategic priority. HSAG presents these programwide conclusions and corresponding recommendations to HHS to drive progress toward achieving the strategic priorities and related objectives of the Iowa HHS Medicaid Quality Strategy and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Iowa Managed Care Program members. Table 8-1 displays each Iowa HHS Medicaid Quality Strategy strategic priority and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (●) impacted the Iowa Managed Care Program's progress toward achieving the applicable priorities, and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to Medicaid members. If no trends were identified through an EQR activity that substantially impacted a priority, or EQR activities did not produce data for an Iowa HHS Medicaid Quality Strategy objective, a dash (–) is noted in Table 8-1.

Table 8-1—Programwide Conclusions and Recommendations

Performance Impact on Strategic Priorities and Objectives		Performance Domain
Strategic Priority 1.0—Access to Care		
✓	The aggregated statewide rate for *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—7-Day and 30-Day Follow-Up—Total* performance measures were at or above the 90th percentile, positively impacting the Iowa HHS Medicaid Quality Strategy objective to *Improve Behavioral Health Network Adequacy*.	☒ Quality ☒ Timeliness ☒ Access
✓	Both PAHPs demonstrated statistically significant improvement in performance as compared to the baseline for the DWP Kids performance indicator for the preventive dental visits PIP activity. These results demonstrate progress for this population toward achieving HHS' Strategic Priority for increasing the number of members who access dental care.	
✗	The statewide aggregate rate for *Access to Dental Services* performance measure for DWP Adults (24.35 percent) and DWP Kids (51.82 percent) indicated that additional opportunities exist to improve these performance measure rates to positively impact HHS' Strategic Priority for increasing the number of members who accessed dental care.	
–	Through the NAV activity, four of five MCPs demonstrated that during the time period under review, they were either not completing a survey or were not comprehensively completing a survey in accordance with HHS indicators for appointment wait times.	

	Performance Impact on Strategic Priorities and Objectives	Performance Domain
–	The EQR activities do not produce sufficient data to assess the impact of the *Improve Access to Maternal Health* and *Improve Access to LTSS Services* Iowa HHS Medicaid Quality Strategy objectives, or the *Sealant Receipt on Permanent First Molars* indicator under the *Improve Access to Primary Care and Specialty Care* objective.	
Strategic Priority 2.0—Whole Person Coordinated Care		
✓	The aggregated statewide HEDIS® rate for *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* was 82.57 percent, which achieved the Iowa HHS Medicaid Quality Strategy objective to *Increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% by SFY2027*.	
✓	The aggregated statewide HEDIS rate for *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total* was 52.26 percent and the *Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total* aggregated statewide HEDIS rate was 19.16 percent, indicating progress was made toward achieving the Iowa HHS Medicaid Quality Strategy objective to *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.*	
✗	The *Timeliness of Prenatal Care* measure had statewide aggregate rates of 84.90 percent, which was a decrease from the prior year, indicating negative impact to the *Improve Prenatal and Postpartum Comprehensive Care Management* Iowa HHS Medicaid Quality Strategy objective.	
●	The aggregated statewide HEDIS rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* increased minimally from 26.94 percent to 27.81 percent, which continues to be an improvement from the 23.6 percent baseline rate identified in the Iowa HHS Medicaid Quality Strategy. This performance demonstrates minimal impact for the Iowa HHS Medicaid Quality Strategy objective to *Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis*.	
●	The *Postpartum Care* measure had a statewide aggregate rate of 83.65 percent for postpartum care, which was a slight increase from the prior year's rate, indicating minimal impact was made to the *Improve Prenatal and Postpartum Comprehensive Care Management* Iowa HHS Medicaid Quality Strategy objective.	
–	While statewide aggregate rates were reported through the PMV activity for MLTSS measures (*Admission to a Facility from the Community*, *Minimizing Facility Length of Stay*, and *Successful Transition After Long-Term Facility Stay*), the Iowa HHS Medicaid Quality Strategy did not include performance targets for these measures. Therefore, the impact to the objective to *Improve Whole Person Coordinated Care for Member Enrolled in LTSS Services* could not be assessed.	

	Performance Impact on Strategic Priorities and Objectives	Performance Domain
Strategic Priority 3.0—Health Equity		
–	The EQR activities did not produce sufficient data to assess the impact to the *Address Disparities in Behavioral Health and Substance Use Disorders*, *Maternal Health*, *Primary and Specialty Care Services*, *LTSS*, and *Oral Health* Iowa HHS Medicaid Quality Strategy objectives. Of note, while performance measures that align with the Iowa HHS Medicaid Quality Strategy objectives are collected through the HEDIS audit process, the data included through the technical report process are not stratified by race, ethnicity, age, or geography.	☒ Quality ☐ Timeliness ☒ Access
–	The aggregated findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact that HHS' value-based arrangements have on reducing disparities in care in the focus area of low birth weight.	
Strategic Priority 4.0—Program Administration		
–	The EQR activities did not produce data to assess the impact on the Grievances, Appeals, and Exception to Policy objective.	☒ Quality ☐ Timeliness ☐ Access
Strategic Priority 5.0—Voice of the Customer		
✓	The MCO Program (i.e., statewide aggregate rate) received a rate of 49.53 percent for the CAHPS measure, *Discussing Cessation Medications*, for the adult Medicaid population, which was higher than the CY 2024 rate.	☒ Quality ☐ Timeliness ☐ Access
✓	For the child Medicaid population *Rating of Personal Doctor* CAHPS measure, the statewide aggregate rate was 79.55 percent, which was statistically significantly higher than the 2024 national average.	
✓	The child Medicaid population *Getting Needed Care* (88.80 percent), *Getting Care Quickly* (91.47 percent), and *How Well Doctors Communicate* (95.96 percent) CAHPS measures were statistically significantly higher than the 2024 national average.	
✓	For the child Medicaid population *Customer Service* CAHPS measure, the statewide aggregate rate was 89.96 percent, which was higher than the CY 2024 rate.	
✓	The adult Medicaid population *Getting Needed Care* (86.43 percent), *Getting Care Quickly* (85.64 percent), and *How Well Doctors Communicate* (95.32 percent) CAHPS measures were statistically significantly higher than the 2024 national average.	
✗	For the adult Medicaid population *Rating of All Health Care* (53.00 percent), *Rating of Specialist Seen Most Often* (61.70 percent), and *Rating of Health Plan* (58.26 percent) CAHPS measures, the statewide aggregate rates were statistically significantly lower than the 2024 national average.	
✗	For the child Medicaid population *Rating of Health Plan* CAHPS measure, the statewide aggregate rate was 67.79 percent, which was lower than the CY 2024 rate and statistically significantly lower than the 2024 national average.	

Performance Impact on Strategic Priorities and Objectives		Performance Domain
–	The aggregated findings for the EQR activities did not produce data for HSAG to comprehensively assess the impact to HHS' focus areas through surveys for continuity of care, experience of care stratified by waiver, and questions around grievances and appeals.	

Recommendations

Based on findings identified through the EQR activities that impacted the goals and objectives in the Iowa HHS Medicaid Quality Strategy, HSAG has identified the following recommendations to support improvement in the quality, timeliness, and access to healthcare services furnished to Iowa Managed Care Program members:

- To further enhance HHS' ability to measure the strategic priorities indicated in the Iowa HHS Medicaid Quality Strategy, HSAG recommends that HHS consider including specific, measurable, attainable, and timely goals and corresponding objectives for each of the strategic priorities and revise the Iowa HHS Medicaid Quality Strategy to reflect these updates. For example, related to the Access to Care strategic priority, HHS could consider adding objectives that tie to national standardized performance measures for all HHS priority areas including behavioral health, maternal health, LTSS, primary care, and specialty care, and set benchmarks for each objective. Additionally, HSAG recommends that HHS consider establishing corresponding objectives that align specifically to dental health outcomes for all five of HHS' strategic priorities within the Iowa HHS Medicaid Quality Strategy, and tie to national standardized performance measures that relate to dental services when available.
- As indicated in the Iowa HHS Medicaid Quality Strategy, HHS plans to contractually require that MCOs engage in two additional PIPs per year (two HSAG validated PIPs and two non-HSAG validated PIPs) that focus on prevention and care of acute and chronic conditions, high risk services, oral health, etc. As such, HSAG continues to recommend that HHS consider selecting the topics for the additional PIPs to ensure alignment with the Iowa HHS Quality Strategy goals and objectives. Additionally, HHS could also require specific interventions (e.g., active, innovative improvement strategies) that MCOs must implement for PIPs with the potential to directly impact the performance indicator outcomes and facilitate comparability among the MCOs.
- When mandating future non-clinical PIP topic areas, HHS could consider requiring the MCPs (i.e., the MCOs and the PAHPs) to design PIPs that address lower-performing member satisfaction survey results as identified through CAHPS and any HHS-mandated or PAHP-implemented dental experience survey. HHS could also require all MCPs to focus an intervention on increasing survey response rates.
- To improve MCP performance in the Grievance and Appeal program area assessed through the compliance review activity, and to ensure that member rights are not being impeded, HHS should consider developing model grievance, adverse benefit determination (ABD), and appeal notices that include all federal and state-specific requirements, as applicable.
- HSAG determined through the compliance review activity that most MCPs maintained a peer-to-peer (P2P) and reconsideration process in which the initial service authorization denial could be overturned by the same practitioner who issued the denial after receipt of additional information or information obtained during the P2P that occurred after issuance of the ABD notice but prior to the appeal process. HSAG recommends that HHS update contract language to ensure that MCPs' P2P processes do not conflict with Medicaid managed care requirements. HHS should also ensure that MCPs track all overturned denials that occur after an ABD is sent to the member through the appeal process, and MCPs obtain member consent when a provider appeals on the member's behalf as required by Medicaid managed care regulations.
- HSAG continues to recommend that HHS issue formal guidance to all MCPs, detailing its expectations for how the MCPs should assess appointment wait time standards and consider revisions to the survey protocol to ensure the MCPs' compliance with State standards are accurately measured. As CMS has implemented appointment timeliness standards effective in 2027, HHS should also ensure that these standards are incorporated into all MCP

Performance Impact on Strategic Priorities and Objectives	Performance Domain
contracts, as applicable. Specifically, to comply with the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F), HHS should implement the following within the required effective dates: – Review the maximum appointment wait times standards (i.e., 15 business days for routine primary care [adult and pediatric] and obstetric/gynecological services; 10 business days for outpatient mental health and substance use disorder [SUD] appointments). • HSAG also continues to recommend that HHS contract with an independent vendor to perform secret shopper surveys of MCP compliance with appointment wait times and accuracy of provider directories and require directory inaccuracies to be sent to HHS within three days of discovery, in accordance with CMS-2439-F. Results from the secret shopper survey will provide assurances to HHS that the MCPs' networks have the capacity to serve the expected enrollment in their service area and that they offer appropriate access to preventive and primary care services for their members. • To also ensure adherence to CMS-2439-F, HHS should confirm that an annual member experience survey for each MCP is conducted and analyze the responses to determine where opportunities for improvement exist and implement initiatives that target improvement. • To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), HHS should update the contracts with its MCPs within the required effective dates for each specific requirement as follows: – Require the MCPs to implement the payer-to-payer, provider access, and prior authorization application programming interfaces (APIs) to improve patient, provider, and payer access to patient data and reduce the burden of prior authorization processes.	

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting External Quality Review Activities

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory external quality review activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), MCPs are required to have a quality assessment and performance improvement program which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve QI
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[17]

HSAG's validation of PIPs includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCPs design, conduct, and report the PIPs in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., aim statement, population, performance indicator(s), sampling methods, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that the reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, the MCP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCPs improve its rates through implementation of effective processes (i.e., barriers analyses, intervention design, and evaluation results).

[17] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 27, 2026.

Technical Methods of Data Collection and Analysis

The HSAG PIP team consisted of, at a minimum, an analyst with expertise in statistics and PIP design and a clinician with expertise in performance improvement processes. HSAG, in collaboration with HHS, developed the PIP Submission Form. Each MCP completed this form and submitted it to HSAG for review. The PIP Submission Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

For the MCP PIPs, HSAG, with HHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs per the CMS protocols. The CMS protocols identify nine steps that should be validated for each PIP.

The nine steps included in the PIP Validation Tool are listed below:

1. Review the Selected PIP Topic
2. Review the PIP Aim Statement
3. Review the Identified PIP Population
4. Review the Sampling Method
5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of PIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate PIPs conducted by the MCPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs (CMS EQR Protocol 1).

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the MCP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met*

validation score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. **Overall Confidence That the PIP Achieved Significant Improvement**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

The MCPs had an opportunity to resubmit a revised PIP Submission Form and additional information in response to HSAG's initial validation scores of *Partially Met* or *Not Met* and to address any General Feedback, regardless of whether the evaluation element was critical or noncritical. HSAG conducted a final validation for any resubmitted PIPs. HSAG offered technical assistance to any MCP that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each MCP. These reports, which complied with 42 CFR §438.364, were provided to HHS and the MCPs.

Description of Data Obtained and Related Time Period

For CY 2025, the MCOs submitted baseline data for the two PIP topics. The MCOs used measure specifications developed by HHS and HSAG for the *SDOH Screening* PIP topic and HEDIS measure specifications for the *Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)* PIP. The PAHPs submitted Remeasurement 3 data for their continued PIP topics. The PAHPs used HHS-defined specifications in collecting their performance indicator data. The measures used for MCP PIPs were related to the domains of quality of care and access to care.

HSAG obtained the data needed to conduct the PIP validation from the MCPs' PIP Submission Form. These forms provide annual performance indicator data and detailed information about each PIPs aim statements, sampling and data collection methods and the QI activities completed. Table A-1 displays a description of the data obtained for each PIP topic.

Table A-1—MCO Data Obtained for Each PIP Topic

ITC PIP Topics	Aim Statements	Sampling Methods	Data Sources
SDOH Screening	1. 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? 2. 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?	Sampling was not used.	• Health Risk Screening responses
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	Does performing targeted interventions for children ages 6-12 years old that have a prescription dispensed for ADHD medication and had at least 3 follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of	Sampling was not used.	• Administrative claims/encounters

ITC PIP Topics	Aim Statements	Sampling Methods	Data Sources
	when the first ADHD medication was dispensed and two of which occurred within 270 days (9 months), result in an increase of 2% points from the baseline rate?		
MOL PIP Topics	**Aim Statements**	**Sampling Methods**	**Data Sources**
SDOH Screening	1. 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? 2. 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?	Sampling was not used.	• Health Risk Screening responses
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	1. Initial Phase: Do targeted interventions increase the percentage of members 6-12 years of age with a prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase? 2. Continuation and Maintenance Phase: Do targeted interventions increase the percentage of members 6-12 years of age with a prescription dispensed for ADHD medication, who	Sampling was not used.	• Administrative claims/encounters

MOL PIP Topics	Aim Statements	Sampling Methods	Data Sources
	remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least 2 follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended?		
WLP PIP Topics	**Aim Statements**	**Sampling Methods**	**Data Sources**
SDOH Screening	1. 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? 2. 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?	Sampling was not used.	• Health Risk Screening responses
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	1. Initiation Phase: Do targeted interventions increase the percentage of members 6-12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase? 2. Continuation and Maintenance Phase: Do targeted interventions increase the percentage of	Sampling was not used.	• Administrative claims/encounters

WLP PIP Topics	Aim Statements	Sampling Methods	Data Sources
	members 6-12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended?		

HSAG obtained the data needed to conduct the PIP validation from each PAHP's annual PIP Submission Form. These forms provide annual performance indicator data and detailed information about each PIP's aim statements, sampling and data collection methods, and the QI activities completed. Table A-2 displays a description of the data obtained for each PIP topic.

Table A-2—PAHP Data Obtained for Each PIP Topic

DDIA PIP Topic	Aim Statements	Sampling Methods	Data Sources
Annual Preventative Dental Visits	1. Do targeted interventions increase the percentage of Dental Wellness Plan (DWP Adults) members 19 years and older who had at least one preventive dental visit during the measurement year? 2. Do targeted interventions increase the percentage of Hawki (Hawki) members 18 years of age and younger who had at least one preventive dental visit during the measurement year? 3. Do targeted interventions increase the percentage of Dental Wellness Plan Kids (DWP Kids) members 18 years of age and younger who had at least one preventive dental visit during the measurement year	Sampling was not used.	• Administrative claims/encounters
MCNA PIP Topic	**Aim Statements**	**Sampling Methods**	**Data Sources**
Increase the Percentage of Dental Services	1. Do targeted interventions increase the percentage of Dental Wellness Plan (DWP Adults) members 19 years and older who had at least	Sampling was not used.	• Administrative claims/encounters

MCNA PIP Topic	Aim Statements	Sampling Methods	Data Sources
	one preventive dental visit during the measurement year? 2. Do targeted interventions increase the percentage of Dental Wellness Plan Kids (DWP Kids) members 18 years of age and younger who had at least one preventive dental visit during the measurement year?		

The MCPs submitted each PIP Submission Form according to the approved timeline. After initial validation, the MCPs received HSAG's feedback, an opportunity for technical assistance, and resubmitted the PIP Submission Form for final validation. Table A-3 and Table A-4 display the indicator measurement periods for all PIP topics for the MCPs.

Table A-3—MCO Measurement Periods for PIP Topics

Data Obtained	Measurement Period
Baseline	January 1, 2024–December 31, 2024
Remeasurement 1	January 1, 2025–December 31, 2025
Remeasurement 2	January 1, 2026–December 31, 2026

Table A-4–PAHP Measurement Periods for Both PIP Topics

Data Obtained	Measurement Period
Baseline	July 1, 2021–June 30, 2022
Remeasurement 1	July 1, 2022–June 30, 2023
Remeasurement 2	July 1, 2023–June 30, 2024
Remeasurement 3	July 1, 2024–June 30, 2025

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the MCP provided to members, HSAG validated the PIPs to ensure the MCP used a sound methodology in its design and PIP implementation. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *High Confidence, Moderate Confidence, Low Confidence* or *No Confidence*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to baseline and the PIP goal) and qualitative results (e.g., technical design of the PIP) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness,

HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members.

Performance Measure Validation

Activity Objectives

The purpose of PMV is to assess the accuracy of performance measures reported by all MCPs and to determine the extent to which performance measures reported by the MCPs follow State specifications and reporting requirements. HSAG also followed the guidelines set forth in CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.[18]

HHS identified a set of performance measures for CMS Core Set reporting that it wanted to include in the validation activity. HHS also identified a set of performance measures that the MCOs and PAHPs were required to calculate and report, which were required to be reported following the CMS MLTSS measure specifications and the measure specifications provided by HHS, respectively.

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that are to be reviewed as part of the validation process. The following list describes the types of data collected and how HSAG analyzed these data:

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The MCPs and the HHS vendor (IBM [19]) were required to submit a completed ISCAT that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation of the required HHS-developed measures, CMS Core Set measures, or CMS MLTSS measures. HSAG reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance measures**—IBM and the MCPs that calculated the performance measures using computer programming language were required to submit source code for each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications defined by HHS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). MCPs that did not use computer programming language to calculate the performance measures were required to submit documentation describing the actions taken to calculate each measure.
- **Supporting documentation**—The MCPs and IBM submitted documentation to HSAG that provided reviewers with additional information necessary to complete the validation process,

[18] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 27, 2026.

[19] IBM was included as part of the PMV activity with the MCPs, as IBM calculated CMS Core Set Reporting performance measure rates at the statewide level using encounter data submitted to HHS by the MCPs.

including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation and identified issues or areas needing clarification for further follow-up.

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV Protocol 2 cited earlier in this report. HSAG obtained a list of the performance measures selected by HHS for validation.

In collaboration with HHS, HSAG prepared a documentation request letter that was submitted to the MCPs and IBM, which outlined the steps in the PMV process. The documentation request letter included a request for the source code for each performance measure, a completed ISCAT, and any additional supporting documentation necessary to complete the audit. The letter also included a timeline for completion and instructions for the MCPs and IBM to submit the required information to HSAG. HSAG responded to any audit-related questions received directly from the MCPs and IBM.

Approximately two weeks prior to the PMV virtual review, HSAG provided MCPs and IBM with an agenda describing all review activities and indicated the type of staff needed for participation in each session. HSAG also conducted a pre-review conference call with the MCPs and IBM to discuss review logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the MCPs and IBM.

PMV Review Activities

HSAG conducted a virtual review with each MCP and the HHS vendor. HSAG collected information using several methods including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual review activities included the following:

- **Opening and organizational review**—This interview session included introductions of HSAG's validation team and key MCP or IBM staff involved in the support of the MCPs' and IBM's information systems and its calculation and reporting of the performance measures. HSAG reviewed expectations for the virtual review, discussed the purpose of the PMV activity, and reviewed the agenda and general audit logistics. This session also allowed the MCPs and IBM to provide an overview of its organizational operations and any important factors regarding its information systems or performance measure activities.
- **Review of key information systems and data processes**—Drawing heavily on HSAG's desk review of the MCPs' and IBM's ISCAT responses, these interview sessions involved key MCP or IBM staff responsible for maintaining the information systems and executing the processes necessary to produce the performance measure rates. HSAG conducted interviews to confirm findings based on its documentation review, expanded, or clarified outstanding questions, and ascertained that written policies and procedures were used and followed in daily practice.

Specifically, HSAG staff evaluated the systems and processes used in the calculation of selected performance measures.

- **Enrollment, eligibility, provider, and claims/encounter systems and processes**—These evaluation activities included a review of key information systems and focused on the data systems and processes critical to the calculation of measures. HSAG conducted interviews with key staff familiar with the collection, processing, and monitoring of the MCP data used in producing performance measures.
- **Overview of data integration and control procedures**—This session included a review of the database management systems' processes used to integrate key source data and the MCPs' and IBM's calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
- **System demonstrations**—HSAG staff requested that MCP and IBM staff demonstrate key information systems, database management systems, and analytic systems to support documented evidence and interview responses.

- **PSV**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across evaluated measures to verify that the MCPs and IBM had appropriately applied measure specifications for accurate rate reporting. The MCPs and IBM provided HSAG with a listing of the data the MCPs had reported to HHS, from which HSAG randomly selected a sample of cases and requested that the MCPs provide proof of service documentation.

Description of Data Obtained and Related Time Period

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- **Information Systems Capabilities Assessment Tool—**HSAG received this tool from each MCP and IBM. The completed ISCATs provided HSAG with background information on the MCPs' and IBM's policies, processes, and data in preparation for the virtual review validation activities.
- **Source Code (Programming Language) for Performance Measures—**HSAG obtained source code from each MCP and IBM. If the MCPs or IBM did not produce source code to generate the performance indicators, the MCPs or IBM submitted a description of the steps taken for measure calculation from the point that the service was rendered through the final calculation process. HSAG reviewed the source code or process description to determine compliance with the performance indicator specifications.
- **Current Performance Measure Results—**HSAG obtained the calculated results from the MCPs and IBM.
- **Supporting Documentation—**This documentation provided additional information needed by HSAG reviewers to complete the validation process. Documentation included performance measure

definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.

- **Virtual Interviews and Demonstrations**—HSAG also obtained information through discussion and formal interviews with key MCP and IBM staff members as well as through systems demonstrations.

Table A-5 shows the data sources used in the CMS Core Set validation of performance measures and the periods to which the data applied. IBM's information has been included to demonstrate its involvement in the MCO PMV.

Table A-5—Description of MCO, PAHP, and IBM CMS Core Set Measure Data Sources

Data Obtained	Time Period to Which the Data Applied					
	ITC	MOL	WLP	DDIA	MCNA	IBM
Completed ISCAT	MY 2024 (January 1, 2024, to December 31, 2024)					
Source code for each performance measure						
Performance measure results						
Supporting documentation						
Virtual on-site interviews and systems demonstrations	October 17, 2025	October 23, 2025	October 21, 2025	October 10, 2025	October 17, 2025	October 28, 2025

Table A-6 shows data sources used in the MCO MLTSS validation of performance measures and the periods to which the data applied.

Table A-6—Description of MCO MLTSS Measure Data Sources

Data Obtained	Time Period to Which the Data Applied		
	ITC	MOL	WLP
Completed ISCAT	MY 2024 (January 1, 2024, to December 31, 2024)		
Source code for each performance measure			
Performance measure results			
Supporting documentation			
Virtual on-site interviews and systems demonstrations	October 17, 2025	October 23, 2025	October 21, 2025

Additionally, HHS provided HSAG with each MCO's audited MY 2024 HEDIS rates for HHS-selected measures, and HSAG reviewed the rates in comparison to national Medicaid percentiles to identify strengths and opportunities for improvement.

Table A-7 shows the data sources used in the validation of state-custom performance measures reported by the PAHPs and the periods to which the data applied.

Table A-7—Description of PAHP State-Custom Measure Data Sources

Data Obtained	Time Period to Which the Data Applied	
	DDIA	MCNA
Completed ISCAT	SFY 2025 (July 1, 2024, to June 30, 2025)	
Source code for each performance measure		
Performance measure results		
Supporting documentation		
Virtual on-site interviews and systems demonstrations	October 10, 2025	October 17, 2025

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that the MCPs provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, *Not Applicable*, or *Not Reported*. HSAG further analyzed the quantitative results (e.g., performance indicator results) and qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. For each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members. Additionally, for each MCO's audited MY 2024 HEDIS rates for HHS-selected measures, strengths were identified as a greater than 5 percent improvement from the prior year or a rate that was above the national Medicaid 75th percentile. Weaknesses were identified as a greater than 5 percent decline from the prior year or a rate that fell at or below the national Medicaid 25th percentile.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the member rights requirements

described in §438.100, the emergency and poststabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with HHS, performed compliance reviews of the MCPs contracted with HHS to deliver services to Iowa Managed Care Program members. HSAG followed the guidelines set forth in CMS' *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*, February 2023.[20]

HHS requires its MCPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. CY 2024 began a new three-year compliance review cycle, in which HSAG reviewed the first half of the federal standards for compliance. The remaining federal standards will be reviewed in CY 2025, and in Year Three (CY 2026), a comprehensive evaluation of the MCPs' implementation of corrective actions taken to remediate any requirements (i.e., elements) that received a *Not Met* score during the first two years of the compliance review cycle (CYs 2024 and 2025).

As demonstrated in Table A-8, HSAG will complete a comprehensive review of compliance with all federal requirements as stipulated in 42 CFR §438.358 within a three-year period.

Table A-8—Iowa Compliance Review Three-Year Cycle for MCPs

Standards	Associated Federal Standards[1]		Year One (CY 2024)	Year Two (CY 2025)	Year Three (CY 2026)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of each MCP's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b)	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1110 §457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	

[20] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 27, 2026.

Standards	Associated Federal Standards[1]		Year One (CY 2024)	Year Two (CY 2025)	Year Three (CY 2026)
	Medicaid	CHIP			
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240(b)		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Part 438 Subpart F).

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

Technical Methods of Data Collection and Analysis

Prior to beginning the CY 2025 compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the findings from the review. The content of the tools was selected based on applicable federal and State regulations and on the requirements set forth in the contract between HHS and the MCPs as they related to the scope of the review. The review processes used by HSAG to evaluate each MCP's compliance were consistent with CMS EQR Protocol 3.

For each MCP, HSAG's desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with HHS to develop scope of work, compliance review methodology, and compliance review tools (i.e., Standards review tools).
- Prepared and forwarded to the MCP a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with each MCP.
- Hosted a pre-site review preparation session with all MCPs.
- Generated a list of five sample case files for grievances, appeals, practitioner credentialing, and organizational credentialing, and three delegation case file reviews.
- Conducted a desk review of supporting documentation the MCP submitted to HSAG.
- Followed up with each MCP, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the site review interview sessions and provided the agenda to the MCP to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCP key program staff members.
- Conducted an IS review of the data systems that the MCP used in its operations, applicable to the standards and elements under review.
- Conducted a review of grievance, appeal, practitioner credentialing, organizational credentialing, and delegation case files.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the MCP.
- Documented findings and assigned each element a score of *Met, Not Met,* or *NA* for the Standards review (as described in the Data Aggregation and Analysis section) within the compliance review tool.
- Prepared an MCP-specific report detailing the findings of HSAG's review.
- Prepared an MCP-specific CAP template and required the MCPs to develop and submit remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to the MCP during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3. The protocol describes the scoring as follows:

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

Not Complete indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.

- Documentation, staff responses, case file documentation, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements not applicable to the MCP were scored *NA* and were not included in the denominator of the total score.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCPs' for grievances, appeals, practitioner credentialing, organizational credentialing, and delegation to verify that the MCPs had put into practice what the MCPs had documented in their policies. HSAG selected five case files each for grievances, appeals, practitioner credentialing, and organizational credentialing, and three delegation case files from the full universe of cases provided by each MCP. The file reviews were not intended to be a statistically significant representation of all the MCPs' files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCP staff members. Based on the results of the file reviews, MCPs must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided to members within the program areas under review, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCP's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCP's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards included as part of the CY 2025 compliance review.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Description of Data Obtained

To assess the MCP's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCP, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas).
- Case files for credentialing and recredentialing records, grievance records, appeal records, and contracts with delegated entities.

HSAG obtained additional information for the compliance review through IS reviews of the MCP's data systems and through interactions, discussions, and interviews with the MCP's key staff members. Table A-9 lists the major data sources HSAG used in determining the MCP's performance in complying with requirements and the time period to which the data applied.

Table A-9—Description of MCP Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	July 1, 2024, through April 30, 2025
Information obtained from a review of a sample of practitioner initial credentialing and recredentialing case files	July 1, 2024, through April 30, 2025
Information obtained from a review of a sample of organizational initial credentialing and recredentialing case files	July 1, 2024, through April 30, 2025
Information obtained from a review of a sample of grievance and appeal case files	July 1, 2024, through April 30, 2025
Information obtained from a review of a sample of delegation case files	July 1, 2024, through April 30, 2025
Information obtained through interviews	July 28, 2025, through August 8, 2025
Documentation submitted post-site review	July 30, 2025, through August 12, 2025

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses for each MCP individually, HSAG used the results of the program areas reviewed, including comprehensive case file reviews for three program areas. As any element not achieving compliance required a formal action plan, HSAG determined each MCP's substantial strengths and weaknesses as follows:

- Strength—Any program area that did not require a CAP (i.e., achieved a compliance score of 100 percent)
- Weakness—Any program area with three or more elements with a *Not Met* score, and/or HSAG determined the plan had one or more egregious deficiencies identified in a program area.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that the MCP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members.

Network Adequacy Validation

Activity Objectives

42 CFR §438.350(a) requires states that contract with MCOs, prepaid inpatient health plans (PIHPs), and PAHPs to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP members across the continuum of services.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of the Iowa HHS defined network adequacy indicators reported by the MCPs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by HHS.

Technical Methods of Data Collection and Analysis

HSAG collected network adequacy data from the MCPs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with CMS EQR Protocol 4.[21]

HSAG conducted a virtual review with the MCPs. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, PSV, observation of

[21] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 27, 2026.

data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each MCP are described below:

- Opening meeting
- Review of ISCAT and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

HSAG conducted interviews with key MCP staff members who were involved with the calculation and reporting of network adequacy indicators.

Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated each MCP's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the MCP's and the State's network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCPs used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Process for Drawing Conclusions

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in HSAG's CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-10.

Table A-10—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have significant bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the

network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table A-11, and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table A-11—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the MCPs provide a root cause analysis of the finding.
- Working with the MCPs to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, HHS requires its contracted MCPs to submit high-quality encounter data. HHS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. In CY 2025, HHS continued to contract with HSAG to conduct an EDV study for both the MCOs and the PAHPs. HSAG's approach to conducting EDV

studies is tailored to address the specific needs of its clients by customizing elements outlined in CMS EQR Protocol 5. [22]

MCOs

For CY 2025, HSAG conducted the following two core evaluation activities:

- **Medical Record Review (MRR)**—Assessed the completeness and accuracy of HHS' electronic encounter data through a comparison with the corresponding members' medical records. The goal of this activity was to validate encounter data using medical records as the source of truth. This activity corresponds to Activity 4: Review Medical Records, in the CMS EQR Protocol 5.
- **Comparative Analysis**—Assessed the completeness and accuracy of HHS' electronic encounter data through a comparison between HHS' electronic encounter data and the data extracted from the MCOs' data systems. The goal of this activity was to evaluate the extent to which the encounter data submitted by the MCOs to HHS were complete and accurate based on corresponding information maintained in the MCOs' data systems. This activity corresponds to Activity 3: Analyze Electronic Encounter Data, in the CMS EQR Protocol 5. As part of this activity, HSAG provided technical assistance to the MCOs that exhibited performance concerns identified through the comparative analysis.

HSAG conducted one or both of these evaluation activities for each of the three MCOs included in the EDV study. Table A-12 lists the MCO names and abbreviations, along with the specific CY 2025 evaluation activities that were conducted for each of the MCOs.

Table A-12—List of MCOs and Core Evaluation Activities

MCO Name	MCO Abbreviation	Core Activity	Study Review Period
Iowa Total Care, Inc.	ITC	MRR	July 1, 2023–June 30, 2024
Molina Healthcare of Iowa	MOL	Comparative Analysis	November 1, 2023–October 31, 2024
		MRR	July 1, 2023–June 30, 2024
WellPoint Iowa, Inc.	WLP	MRR	July 1, 2023–June 30, 2024

For MOL, HSAG previously conducted a comparative analysis during the prior year; however, the evaluation was limited to four months of data because MOL did not begin serving Iowa Medicaid managed care members until July 1, 2023. In the current EDV cycle, HSAG conducted a more comprehensive comparative analysis using a full year of data. This expanded scope allowed for a more

[22] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 27, 2026.

complete assessment of trends and potential areas for improvement as **MOL** continues to integrate into the Iowa Medicaid program.

PAHPs

For CY 2025, HSAG conducted the following core evaluation activity for **DDIA** and **MCNA**:

- **Comparative Analysis**—Assessed the completeness and accuracy of HHS' electronic encounter data and the data extracted from the PAHPs' data systems. The goal of this activity was to evaluate the extent to which encounters submitted by the PAHPs to HHS were complete and accurate based on corresponding information maintained in the PAHPs' data systems. As part of this activity, HSAG provided technical assistance to the PAHPs that exhibited performance concerns identified through the comparative analysis.

Technical Methods of Data Collection and Analysis

MCOs

Medical Record Review

All three MCOs (i.e., **ITC**, **MOL**, and **WLP**) were included in this component of the EDV activity for CY 2025. The technical methodology for data collection and analysis for the EDV activity involved several key components:

- **Eligible Population Identification and Sampling**: HSAG identified continuously enrolled in the same MCO during the study period (i.e., from July 1, 2023, through June 30, 2024) and generated a sample of members based on this eligibility. Random sampling was used to select 411 members[23] from the eligible population for each MCO. The SURVEYSELECT procedure in SAS®,[24] was used to randomly select one physician visit for each sampled member. HSAG refers to "physician visits" as services that met all the criteria outlined in Table A-13.
- **Medical Record Procurement**: Each MCO procured the sampled members' medical records from its contracted providers and submitted the records to HSAG through a secure data exchange platform. To improve procurement rates, HSAG conducted a technical assistance session to guide MCOs in the procurement process.
- **Review Process**: HSAG's trained reviewers verified whether the selected service date from HHS' encounter data could be matched with the medical record. The reviewers then examined the services associated with the selected date of service and validated the data elements listed in Table A-14. For any discrepancies, reviewers documented omissions or inaccuracies.

[23] The sample size of 411 was based on a 95 percent confidence level and a margin of error of 5 percent.
[24] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

- **Data Collection and Tool**: An HSAG-designed electronic data collection tool was used to ensure consistency in documenting findings. This tool included built-in checks to ensure data accuracy.
- **Data Validation and Quality Control**: HSAG reviewers underwent thorough training and interrater reliability testing, and the collected data was cross-checked to ensure consistency and accuracy throughout the review process.
- **Review Indicators and Analysis**: After the data collection, HSAG analysts conducted data analysis using specific review indicators. Table A-13 displays the review indicators that were used to report the medical record review results.

Table A-13—Criteria for Defining Physician Visits

Data Element	Criteria
Provider Taxonomy Classification or Provider Type	02–Physician MD
	03–Physician DO
	05–Podiatrist
	13–Rural Health Clinic
	14–Clinic
	38–Certified Nurse Midwife
	44–Certified Registered Nurse Anesthetist (CRNA)
	49–Federally Qualified Health Center (FQHC)
	50–Nurse Practitioner
	68–Physician Assistant
Place of Service	02–Telehealth
	10–Telehealth Provided in Patient's Home
	11–Office
	17–Walk-in Retail Health Clinic
	20–Urgent Care Facility
	49–Independent Clinic
	50–FQHC
	71–Public Health Clinic
	72–Rural Health Clinic
Procedure Code	If all detail lines for a visit had the following procedure codes, the visit was excluded from the study since these procedure codes are for services outside of the scope of work for this study (e.g., durable medical equipment [DME], dental, vision, and ancillary providers). • A procedure code starting with "B," "E," "D," "K," or "V." • Procedure codes between A0021 and A0999 (i.e., codes for transportation services).

Data Element	Criteria
	• Procedure codes between A4206 and A9999 (i.e., codes for medical and surgical supplies, miscellaneous, and investigational). • Procedure codes between T4521 and T4544 (i.e., codes for incontinence supplies). • Procedure codes between L0112 and L4631 (i.e., codes for orthotic devices and procedures). • Procedure codes between L5000 and L9900 (i.e., codes for prosthetic devices and procedures). • Procedure codes with an "F" in the fifth digit. • Procedure codes related to blood pressure quality measures (i.e., G8476, G8477, G8752, G8753, G8754, G8755, G8783, G8785, G8950, and G9273).

Table A-14—Key Data Elements for MRR

Key Data Element	
Date of Service	Diagnosis Code
Procedure Code[1]	Procedure Code Modifier

[1] The procedure code key data element analysis was based on the Current Procedure Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS).

Table A-15—Study Indicators

Study Indicator	Denominator	Numerator
Medical Record Procurement Rate: Percentage of medical records submitted for the sampled date of service. Additionally, the reasons for missing or unsubmitted medical records were presented.	Total number of requested sample cases.	Number of requested sample cases with medical records submitted for the sampled date of service.
Second Date of Service Submission Rate: Percentage of sample cases with a second date of service submitted in the medical records.	Total number of requested sample cases.	Number of sample cases with a second date of service submitted in the medical records.
Medical Record Omission Rate: Percentage of data elements (e.g., *Date of Service* data element) identified in HHS' data warehouse that were not found in the members' medical records. HSAG calculated the study indicator for each data element listed in Table A-14.	Total number of data elements (e.g., *Date of Service* data element) identified in HHS' data warehouse (i.e., based on the sample dates of service and the second dates of service that were found in HHS' data warehouse).	Number of data elements (e.g., *Date of Service* data element) in the denominator but not found in the medical records.

Study Indicator	Denominator	Numerator
Encounter Data Omission Rate: Percentage of data elements (e.g., *Date of Service* data element) identified in members' medical records but not found in HHS' data warehouse. HSAG calculated the study indicator for each data element listed in Table A-14.	Total number of data elements (e.g., *Date of Service* data element) identified in members' medical records (i.e., based on the medical records procured for the sample dates of service and second dates of service).	Number of data elements (e.g., *Date of Service* data element) in the denominator but not found in HHS' data warehouse.
Diagnosis Code Accuracy: Percentage of diagnosis codes supported by the medical records. Additionally, the frequency count of associated reasons for inaccuracy were presented.	Total number of diagnosis codes that met the following two criteria: • For dates of service (i.e., including both the sample dates of service and the second dates of service) that existed in both HHS' encounter data and the medical records. • Diagnosis codes present for both HHS' encounter data and the medical records.	Number of diagnosis codes supported by the medical records.
Procedure Code Accuracy: Percentage of procedure codes supported by the medical records. Additionally, the frequency count of associated reasons for inaccuracy were presented.	Total number of procedure codes that met the following two criteria: • For dates of service (i.e., including both the sample dates of service and the second dates of service) that existed in both HHS' encounter data and the medical records. • Procedure codes are present for both HHS' encounter data and the medical records.	Number of procedure codes supported by the medical records.
Procedure Code Modifier Accuracy: Percentage of procedure code modifiers supported by the medical records.	Total number of procedure code modifiers that met the following two criteria: • For dates of service (i.e., including both the sample dates of service and the second dates of service) that existed in both HHS'	Number of procedure code modifiers supported by the medical records.

Study Indicator	Denominator	Numerator
	encounter data and the medical records. • Procedure code modifiers present for both HHS' encounter data and the medical records.	
All-Element Accuracy Rate: Percentage of dates of service present in both HHS' encounter data and the medical records, with the same values for all data elements listed in Table A-14.	Total number of dates of service (i.e., including both the sample dates of service and second dates of service) that were in both HHS' encounter data and the medical records.	The number of dates of service in the denominator with the same diagnosis codes, procedure codes, and procedure code modifiers for a given date of service.

Comparative Analysis (MOL only)

For CY 2025, only **MOL** was included in this component of the EDV activity. For this activity, HSAG developed data requirement documents requesting claims/encounter data from both HHS and **MOL**. HSAG also held a follow-up technical assistance session approximately one week after distributing the data requirement documents that allowed **MOL** time to review the requirements and prepare its questions for the meeting.

HSAG used data from both HHS and **MOL** with dates of service from November 1, 2023, through October 31, 2024, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources (i.e., HHS and **MOL**) represented the same universe of encounters, the data targeted professional, institutional, and pharmacy encounters with final[25] adjudication status on or before March 31, 2025, and submitted to HHS on or before April 30, 2025. This approach ensured that the dataset reflected finalized encounters as of the anchor date, allowing sufficient time for encounters to be submitted, processed, and available in the HHS data warehouse for evaluation. Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following four basic checks:

- Data extraction—Verified that the data were extracted according to the Data Submission Requirement (DSR) document.
- Percentage present—Confirmed that all required data fields were present on the file and had values in those fields.
- Percentage of valid values—Assessed whether the data values provided were valid and aligned with the expected values (e.g., valid International Classification of Diseases, 10th Revision [ICD-10] codes in the diagnosis fields).

[25] For this study the term "final" refers to the most recent paid or denied iteration of the encounter on or before the cut-off date of March 31, 2025.

- Evaluation of matching claim numbers—Measured the percentage of claim numbers that matched between the data extracted from HHS' data warehouse and data submitted by **MOL** to HSAG.

Based on the preliminary file review results, HSAG generated a report that highlighted any major findings and requested that HHS and/or **MOL** provide written feedback, and if necessary, resubmit data.

Once HSAG received and processed the final datasets, HSAG conducted a series of analyses to assess completeness and accuracy. To facilitate the presentation of findings, the comparative analysis was divided into three analytic sections: **Record Completeness**, **Data Element Completeness and Accuracy**, and **Overall Encounter Accuracy**.

- **Comparative Analysis—Record Completeness**: HSAG assessed record-level data completeness using the following metrics for each encounter data type:
  - **Record Omission**—Records present in **MOL**'s submitted data files but not in HHS' data warehouse.
  - **Record Surplus**—Records present in HHS' data warehouse but not in **MOL**'s submitted data files.
- **Comparative Analysis—Data Element Completeness and Accuracy**: Based on the number of records present in both data sources (i.e., HHS and **MOL**), HSAG further examined completeness and accuracy for key data elements listed in Table A-16. The analyses focused on an element-level comparison for each data element in which HSAG evaluated the element-level completeness based on the following metrics:
  - **Element Omission**: The number and percentage of records with values present in the **MOL**-submitted files but not in HHS' data warehouse.
  - **Element Surplus**: The number and percentage of records with values present in HHS' data warehouse but not in the **MOL**-submitted files.
  - **Element Missing Values**: The number and percentage of records with values missing from both HHS' data warehouse and the **MOL**-submitted files.
  - **Element Accuracy**: The number and percentage of records with the same values in both HHS' and **MOL**'s data sources.
  - **All-Element Accuracy**: The number and percentage of records with the same values across all key data elements relevant to each encounter data type.
- **Comparative Analysis—Overall Encounter Accuracy**: HSAG assessed overall encounter accuracy by evaluating the completeness and consistency of claims. The analysis compared **MOL**'s data files to the corresponding HHS data files and vice versa. HSAG categorized encounter accuracy into these three levels:
  - **Match**—The claim number was present in both data files with all associated detail lines and key data elements (as listed in Table A-16) fully matching.
  - **No Match**—The claim number was present in the primary files but not found in the secondary files.
  - **Partial Match**—The claim number was present in both data files, but detail lines or key data elements contained discrepancies. For example, if a claim in the primary file contained three

detail lines, but only two matching lines were found in the secondary file, the encounter was classified as a Partial Match.

Table A-16—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Member Identification (ID)	✓	✓	✓
Dates of Service			
Detail Service From Date	✓		
Detail Service To Date	✓		
Header Service From Date		✓	✓
Header Service To Date		✓	
Admission Date		✓	
Provider Information			
Billing Provider NPI	✓	✓	✓
Rendering Provider NPI	✓		
Attending Provider NPI		✓	
Prescribing Provider NPI			✓
Referring Provider NPI	✓	✓	
Diagnosis and Procedure Codes Information			
Primary Diagnosis Code	✓	✓	
Secondary Diagnosis Code(s)	✓	✓	
Procedure Code (CPT, HCPCS)	✓	✓	
Procedure Code Modifier(s)	✓	✓	
Units of Service	✓	✓	
Surgical Procedure Code(s)		✓	
National Drug Code (NDC)	✓	✓	✓
Drug Quantity			✓
Revenue Code		✓	
Diagnosis-Related Group (DRG) Code		✓	
Payment Information			
Header Paid Amount		✓	✓
Detail Paid Amount	✓	✓	
Dispensing Fee			✓

Technical Assistance

As a follow-up to the comparative analysis activity, HSAG provided technical assistance to HHS and **MOL** to address findings from the comparative analysis. First, HSAG prepared a **MOL**-specific encounter data discrepancy report highlighting key areas for investigation. The evaluation metrics warranting investigation included:

- An omission or surplus rate that exceeded 5 percent.
- An accuracy rate falling below 95 percent.

Once HHS reviewed and approved the data discrepancy report, HSAG distributed the report to **MOL**, along with data samples to assist with its internal investigation. HSAG collaborated with HHS and **MOL** to review the potential root causes of the key issues and requested written responses from **MOL**'s investigative efforts. Lastly, after reviewing the written responses, HSAG followed up with **MOL**, as needed, and worked with HHS to determine whether the issues had been adequately addressed. This collaborative approach ensured that the data discrepancies were addressed systematically, and that underlying issues were resolved to improve the quality of encounter data.

PAHPs

Comparative Analysis

For CY 2025, both PAHPs (i.e., **DDIA** and **MCNA**) were included in this component of the EDV activity. For this activity, HSAG developed data requirement documents requesting claims/encounter data from both HHS and the PAHPs. HSAG also held a follow-up technical assistance session approximately one week after distributing the data requirement documents that allowed the PAHPs time to review the requirements and prepare their questions for the meeting.

HSAG used data from both HHS and the PAHPs with dates of service from July 1, 2023, through June 30, 2024, to evaluate the accuracy and completeness of the dental encounter data. To ensure that the extracted data from both sources (i.e., HHS and the PAHPs) represented the same universe of encounters, the data targeted dental encounters with a paid/adjudication date on or before November 30, 2024, and submitted to HHS on or before December 31, 2024.

This anchor date allowed enough time for the encounters to be submitted, processed, and available for evaluation in the HHS data warehouse. Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure that data were sufficient to conduct the evaluation. The preliminary file review included the following four basic checks:

- Data extraction—Verified that the data were extracted according to the DSR document.
- Percentage present—Confirmed that all required data fields were present on the file and had values in those fields.

- Percentage of valid values—Assessed whether the data values provided were valid and aligned with the expected values (e.g., valid CDT codes in the *CDT* field).
- Evaluation of matching claim numbers—Measured the percentage of claim numbers that matched between the data extracted from HHS' data warehouse and data submitted by the PAHPs to HSAG.

Based on the preliminary file review results, HSAG generated a report that highlighted any major findings and requested that HHS, **DDIA**, and/or **MCNA** provide written feedback and, if necessary, resubmit data.

Once HSAG received and processed the final data datasets, HSAG conducted a series of analyses to assess data completeness and accuracy, which were divided into three analytic sections. **Record Completeness**, **Data Element Completeness and Accuracy**, and **Overall Encounter Accuracy**.

- **Comparative Analysis—Record Completeness**: HSAG assessed record-level data completeness using the following metrics for the dental encounter data type:
  - **Record Omission**—Records present in the PAHPs' submitted data files but not in HHS' data warehouse.
  - **Record Surplus**—Records present in HHS' data warehouse but not in the PAHPs' submitted data files.
- **Comparative Analysis—Data Element Completeness and Accuracy**: Based on the number of records present in both data sources (i.e., HHS and PAHPs), HSAG further examined completeness and accuracy for key data elements listed in Table A-17. The analyses focused on an element-level comparison for each data element in which HSAG evaluated the element-level completeness based on the following metrics:
  - **Element Omission**: The number and percentage of records with values present in the PAHPs' submitted files but not in HHS' data warehouse.
  - **Element Surplus**: The number and percentage of records with values present in HHS' data warehouse but not in the PAHPs' submitted files.
  - **Element Missing Values**: The number and percentage of records with values missing from both HHS' data warehouse and the PAHPs' submitted files.
  - **Element Accuracy**: The number and percentage of records with the same values in both HHS' and PAHPs' data sources.
  - **All-Element Accuracy**: The number and percentage of records with the same values across all key data elements.
- **Comparative Analysis—Overall Encounter Accuracy**: HSAG assessed overall encounter accuracy by evaluating the completeness and consistency of claims. The analysis compared the PAHPs' data files to the corresponding HHS data files and vice versa. HSAG categorized encounter accuracy into these three levels:
  - **Match**—The claim number was present in both data files with all associated detail lines and key data elements (as listed in Table A-17) fully matching.

- **No Match**—The claim number was present in the primary files but not found in the secondary files.
- **Partial Match**—The claim number was present in both data files, but detail lines or key data elements contained discrepancies. For example, if a claim in the primary file contained three detail lines, but only two matching lines were found in the secondary file, the encounter was classified as a Partial Match.

Table A-17—Key Data Elements for Comparative Analysis

Key Data Elements
Member Identification (ID)
Dates of Service
Detail Service From Date
Detail Service To Date
Header Service From Date
Header Service To Date
Provider Information
Billing Provider NPI
Rendering Provider NPI
Procedure Code and Tooth Specific Information
Procedure Code (CDT Code)
Units of Service
Tooth Number
Tooth Surface (1 through 5)
Oral Cavity Code (1 through 5)
Payment Information
Header Paid Amount
Detail Paid Amount

Technical Assistance

Based on study findings, HSAG initiated a series of follow-up activities designed to assist the PAHPs in addressing and resolving major encounter data issues identified from this study. First, HSAG distributed the data discrepancy reports to each PAHP, which included a description of key issues for the PAHPs to review. Additionally, examples of encounters highlighting identified issues were also distributed to further assist the PAHPs in reviewing the results.

The evaluation metrics warranting investigation included:

- An omission or surplus rate that exceeded 5 percent.
- An accuracy rate falling below 95 percent.

Second, HSAG conducted collaborative technical assistance sessions with HHS and the PAHPs to discuss major data issues identified in the study. During the technical assistance sessions, HSAG, HHS, and the PAHPs reviewed the findings and worked to distinguish true data quality issues from discrepancies related to how the study files were prepared and submitted. The PAHPs were required to submit written responses describing any resolutions or follow-up actions resulting from these discussions.

Description of Data Obtained and Related Time Period

MCOs

Medical Record Review

Data obtained from HHS included:

- Encounter data with dates of service from July 1, 2023, through June 30, 2024.
- Member demographic and enrollment data.
- Provider data.

Data obtained from the MCOs included:

- Medical records for services rendered from July 1, 2023, through June 30, 2024.

Comparative Analysis

HSAG used data from both HHS and **MOL** with dates of service from November 1, 2023, through October 31, 2024, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources (i.e., HHS and **MOL**) represented the same universe of encounters, the analysis focused on professional, institutional, and pharmacy encounters with a final[26] adjudication status on or before March 31, 2025, and submitted to HHS on or before April 30, 2025. This anchor date allowed enough time for the encounters to be submitted, processed, and available for evaluation in the HHS data warehouse.

PAHPs

Comparative Analysis

HSAG used data from both HHS and the PAHPs with dates of service from July 1, 2023, through June 30, 2024, to evaluate the accuracy and completeness of the dental encounter data. To ensure that the extracted data from both sources (i.e., HHS and the PAHPs) represented the same universe of encounters, the data targeted dental encounters with dental encounters with a paid/adjudication date on or before November 30, 2024, and submitted to HHS on or before December 31, 2024. This anchor date

[26] For this study the term "final" refers to the most recent paid or denied iteration of the encounter on or before the cut-off date of March 31, 2025.

allowed enough time for the encounters to be submitted, processed, and available for evaluation in the HHS data warehouse.

Process for Drawing Conclusions

To draw conclusions about the quality of each MCP's encounter data submissions to HHS, HSAG evaluated the results based on the EDV core activities. HSAG calculated the predefined study indicators and/or metrics associated with each of the study components. Since HHS had not yet established standards for results from these activities, to identify strengths and weaknesses, HSAG assessed the results based on the prior year's results, when available. HSAG also leveraged its extensive experience working with other states in assessing the completeness and accuracy of MCPs' encounter data submissions to the State. This approach provided a comparative framework that enabled a thorough assessment of each MCP's performance. HSAG determined each MCP's substantial strengths and weaknesses as follows:

- Strength—Identified areas where data completeness and accuracy were consistently high, highlighting best practices and successful methodologies implemented by the MCPs.
- Weakness—Highlighted areas with recurring data discrepancies, assessing the impact on overall data reliability and compliance with HHS' requirements.

Additionally, for each identified weakness, HSAG provided recommendations to support improvements in the quality and timeliness of encounter data submissions to HHS, aiming to enhance data integrity and ensure alignment with state requirements.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

This activity assesses the experiences of adult members and parents/caretakers of child members with an MCO and its providers, and the quality of care they received. The goal of the CAHPS Health Plan Surveys is to provide feedback that is actionable and will aid in improving the overall experiences of members.

Technical Methods of Data Collection and Analysis

Three populations were surveyed for the MCOs: adult Medicaid, child Medicaid, and CCC Medicaid. Center for the Study of Services (CSS) administered the 2025 CAHPS surveys for **WLP**, and SPH Analytics administered the 2025 CAHPS surveys for **ITC** and **MOL**. Both are NCQA-certified vendors.

The technical methods of data collection were through the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult population, the CAHPS 5.1H Child Medicaid Health Plan Survey (with the CCC measurement set) to **WLP**'s and **MOL**'s child Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (without the CCC measurement set) to **ITC**'s child Medicaid population. **ITC**, **MOL**, and **WLP** used a mixed-mode methodology for data collection (i.e., mail and telephone). **ITC**, **MOL**, and

WLP respondents were given the option of completing the survey in Spanish, as well as completing the survey on the Internet.

CAHPS Measures

The survey questions were categorized into various measures of member experience. These measures included four global ratings, four composite scores, and three medical assistance with smoking and tobacco use cessation items (adult population only). Additionally, five CCC composite measures/items were used for the CCC-eligible population.[27] The global ratings reflected patients' overall member experience with their personal doctor, specialist, health plan, and all health care. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care*, *How Well Doctors Communicate*). The CCC composite measures/items evaluated the experience of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The medical assistance with smoking and tobacco use cessation items assessed the various aspects of providing assistance with smoking and tobacco use cessation.

Top-Box Score Calculations

For each of the four global ratings, the percentage of respondents who chose the top experience rating (i.e., a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box score).

For each of the four composite measures and five CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive or top-box response for the composite measures and CCC composites/items was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite measures and CCC composite measures/items. For the medical assistance with smoking and tobacco use cessation items, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as NA (Not Applicable).

NCQA National Average Comparisons

HSAG compared each MCO's and the MCO program's (i.e., **ITC**, **MOL**, and **WLP** combined) results to the 2024 NCQA national averages to determine if the results were statistically significantly different. Arrows in the tables note statistically significant differences. An upward arrow (↑) indicates a top-box score was statistically significantly higher than the 2024 NCQA national average. Conversely, a downward arrow (↓) indicates a top-box score was statistically significantly lower than the 2024 NCQA national average. In some instances, the scores presented for the MCOs were similar, but one

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

was statistically significantly different from the national average and the other was not. In these instances, it was the difference in the number of respondents between the MCOs that explained the different statistical results. It is more likely that a statistically significant result will be found in an MCO with a larger number of respondents. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as NA.

Description of Data Obtained and Related Time Period

Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2024, and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2024. Adult members and parents or caretakers of child members completed the surveys from February to May 2025.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each MCO provided to members, HSAG assigned each of the measures to one or more of these three domains and compared each MCO's and the MCO program's (i.e., MCOs combined) 2025 survey results to the 2024 NCQA national averages to determine if there were any statistically significant differences. This assignment to domains is depicted in Table A-18.

Table A-18—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Advising Smokers and Tobacco Users to Quit (adult population only)	✓		
Discussing Cessation Medications (adult population only)	✓		
Discussing Cessation Strategies (adult population only)	✓		
Access to Specialized Services (CCC population only)	✓		✓
FCC: Personal Doctor Who Knows Child (CCC population only)	✓		
Coordination of Care for Children with Chronic Conditions (CCC population only)	✓		
Access to Prescription Medicines (CCC population only)	✓		✓
FCC: Getting Needed Information (CCC population only)	✓		

Scorecard

Activity Objectives

On November 8, 2018, CMS published the Medicaid and CHIP Managed Care Proposed Rule (CMS-2408-P) in the Federal Register. As per 42 CFR §438.334, each state contracting with an MCO to provide services to Medicaid members must adopt and implement a quality rating system (QRS). While the EQR protocol is not available yet for the QRS, on May 10, 2024, CMS published the final rule, which advised that Medicaid and CHIP (MAC) QRS or alternative QRS should align with the Medicare Advantage and Part D QRS, Marketplace QRS, the Medicaid and CHIP Child Core Set, the Medicaid Adult Core Set, and other similar CMS initiatives such as the Medicaid and CHIP Scorecard and the CMS Universal Foundation. The final rule includes a mandatory measure list, an initial rating methodology (either CMS' methodology or a CMS-approved alternative methodology has to be used), and the creation of a mandatory website by each state.

The scorecard is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection and Analysis

MCO performance was evaluated in six separate reporting categories, identified as important to consumers.[28] Each reporting category consists of a set of measures that were evaluated together to form a category summary score. The reporting categories and descriptions of the types of measures they contain are listed below:

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

[28] National Committee for Quality Assurance. "Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports for Consumers." October 1998.

HSAG computed six reporting category summary scores and 15 subcategory summary scores for the MCO. HSAG compared each measure to 2025 NCQA Quality Compass national Medicaid HMO benchmarks and assigned star ratings for each measure. HSAG used the following methodology to assign a star rating for each individual measure:

Table A-19—Measure Rate Star Rating Descriptions

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

In instances where data were missing (i.e., the audit designation was *Not Reported [NR], Biased Rate [BR],* or *Not Applicable [NA]*), HSAG handled the missing rates for measures as follows:

- Rates with an *NR* designation were assigned 1-star.
- Rates with a *BR* designation were assigned 1-star.
- Rates with an *NA* designation were assigned a weight of zero.

To provide a more accurate rating of each performance measure, HSAG also assigned partial stars based on how close the rating was to the next star. Because a rating of five stars is the maximum star rating possible, HSAG only calculated partial stars for ratings below five stars. HSAG compared each MCO's rate to the national Medicaid percentiles to determine the percentile range (i.e., the lower and upper percentile bounds) the rate fell between (e.g., between the 25th and 50th percentiles) for calculating the partial star ratings at the measure level. For a one-star rating (i.e., below the 25th percentile), the 10th percentile was used as the lower percentile bound. The partial star rating for each measure was derived using the following formula:

$$Partial\ Star\ Rating = Star\ Rating + \left[\frac{(MCO\ Rate - PV_0)}{(PV_1 - PV_0)}\right]$$

Where: PV_0 = the actual rate value for the lower percentile bound
PV_1 = the actual rate value for the upper percentile bound
Star Rating = the star rating assigned for the MCO's rate (i.e., 1, 2, 3, or 4)
MCO Rate = the reported measure rate for the MCO

For example, if the national Medicaid 25th percentile was 40 percent, the national Medicaid 50th percentile was 60 percent, and an MCO had a rate of 45 percent for a measure, the MCO received two stars for falling between the 25th and 49th percentiles. The partial star rating was calculated as follows:

$$Partial\ Star\ Rating = 2 + \left[\frac{(45 - 40)}{(60 - 40)}\right] = 2.25$$

Once the partial star rating was calculated for each measure, the summary scores for the six reporting categories (Doctors' Communication and Patient Engagement, Access to Preventive Care, Women's Health, Living With Illness, Behavioral Health, and Medication Management) and 15 subcategories (Satisfaction with Providers, Patient Engagement, Access, Preventive Care, Screening for Women, Maternal Health, Diabetes, Cardiovascular, Respiratory, Follow-Up Care, Adults on Antipsychotics, Children on Antipsychotics, Adults on Antidepressants, Antibiotic Stewardship, and Opioids) were calculated by taking the weighted average of all partial star ratings for all measures within the category and then rounding to the nearest star.

A five-level rating scale provides consumers with an easy-to-read "picture" of quality performance for the MCO and presents data in a meaningful manner. The MCO Scorecard uses stars to display MCO performance as follows:

Table A-20—MCO Scorecard Performance Ratings

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

Description of Data Obtained and Related Time Period

HSAG analyzed MY 2024 HEDIS results, including MY 2024 CAHPS data from three MCOs (**ITC**, **MOL**, and **WLP**), for presentation in the 2025 Iowa Medicaid Scorecard.