



# Iowa Medicaid Provider Enrollment Revalidation Strategy

July 1, 2026 – June 30, 2028

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**Lee Grossman**  
Iowa Medicaid Director  
June 5, 2026

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Human Services

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# Executive Summary

The State of Iowa is committed to safeguarding taxpayer dollars by preventing fraud, waste, and abuse in Medicaid. Iowa Medicaid has developed a comprehensive two-year Provider Revalidation Strategy in response to the request communicated by Centers for Medicare & Medicaid Services (CMS) Administrator Oz on April 23, 2026. The request includes enhanced program integrity, accelerated high-risk provider action, and strengthened anti-fraud alignment. In response, Iowa Medicaid submitted a letter of commitment on May 4, 2026, affirming its intention to swiftly revalidate all high-risk providers, including those without National Provider Identifiers (NPIs), and to deliver a full revalidation strategy before June 5, 2026.

The Iowa statewide revalidation initiative will occur in two phases, spanning July 1, 2026, through June 30, 2028. Iowa Medicaid will transition to a controlled, wave-based method of issuing revalidation notifications. Rather than issuing notices to the entire provider population at once, the State will send notices in overlapping waves beginning with high-risk providers, followed by those already past due, and concluding with all other providers. Each wave will provide approximately 30 days for providers to complete their revalidation before the next wave is sent.

A statewide revalidation effort of this scale requires coordinated, timely communication and clear guidance for providers, managed care partners, stakeholders, and internal staff. Iowa Medicaid will implement a streamlined communication and training strategy to ensure all parties understand requirements, timelines, expectations, and operational impacts.

Iowa's provider revalidation plan will generate both direct and indirect costs such as system modifications, increased call center demand, mail processing, and the need for additional staff training. Some of these costs are expected to be partially offset by efficiencies achieved through recent data quality improvement initiatives. Iowa Medicaid has submitted a Provider Advanced Planning Document (APD) to CMS. This APD will outline the system enhancements, operational changes, and resource needs required to address the areas for improvement. The APD will reflect anticipated direct costs, as well as the projected operational savings associated with more accurate provider data and streamlined revalidation processes.

Iowa Medicaid will apply consistent, quantifiable metrics to track progress, identify risks, and ensure compliance with federal expectations. Metrics will inform internal decision-making and, where appropriate, be incorporated into public-facing dashboards.

## Revalidation Phases and Provider Targeting

Phase	Target Providers	Notes / Criteria	Distinct Tax ID Count
<b>Phase 1</b>	Providers with state-issued atypical NPIs; Providers that are past due for revalidation	Focus on early identification and enhanced oversight	9,350
<b>Phase 1 – High/Moderate Risk Provider Types</b>	Home health agency; durable medical equipment & supplies; Physical therapy; Rehabilitation agency; Community mental health center; Intermediate care facility; Hospice	Frequently categorized as high or moderate risk	318
<b>Phase 1 – Escalated to High-Risk</b>	Behavior Analysts (BA); HCBS providers	Categorized at limited risk providers identified through risk indicators will be elevated to high risk	25
<b>Phase 1 – Risk Indicators</b>	Payment suspension; Overpayments; OIG exclusion (past 10 yrs); Enrollment after moratorium lift	Indicators trigger prioritization for early review	31
<b>Phase 2</b>	All remaining enrolled providers	Off-cycle revalidation for remaining providers	5,960

Iowa Medicaid is committed to completing this two-year revalidation effort with clear communication, consistent processes, and strong accountability. We will provide the guidance and support providers need to complete revalidation smoothly while ensuring members continue to receive uninterrupted care. By following this plan with diligence and transparency, Iowa Medicaid will create a reliable, efficient revalidation process that strengthens the provider network and reinforces public trust that taxpayer dollars support legitimate, high-quality services.

# Strategy and Operational Framework

## Current State Assessment

Over the past year, Iowa Medicaid has implemented important improvements to data integrity, workflow automation, provider visibility, and staffing preparedness. These include automation, validation, duplicate-prevention controls, enhanced oversight of owners and managing employees, discrepancy detection, uniform screening procedures, and improved rendering-provider capture on claims. Additional enhancements—such as address validation, centralized screening application programming interface (APIs), and auto-deactivation—are in progress.

The strategy also outlines clear metrics to measure progress and strengthen program integrity. Iowa Medicaid will monitor revalidation completion rates by risk categories, provider response rates, screening results, enforcement actions, data-discrepancy resolution, updates to provider directories, and the transition of atypical providers to NPIs. Public-facing dashboards will increase transparency by reporting revalidation progress, directory accuracy, and program integrity outcomes.

Ongoing surveillance of provider information is supported by monthly automated checks against national and state data sources. Iowa Medicaid continues to strengthen consistency and alignment of provider data across fee-for-service (FFS) and managed care delivery systems, verification, and enforcement of managed care plan (MCP) directory accuracy through contractual reporting requirements.

The strategy further formalizes Iowa Medicaid's collaboration with law enforcement, including the Medicaid Fraud Control Unit (MFCU), CMS Center for Program Integrity (CPI), state oversight entities, Program Integrity referrals, potential case escalations, and data-driven fraud detection.

### **This two-year Provider Revalidation Strategic Plan positions Iowa Medicaid to:**

- Complete revalidation of all providers
- Transition atypical providers to standard NPIs
- Strengthening Medicare-aligned screening practices and system modernization
- Improve statewide provider directory accuracy
- Reduce manual processing through automation
- Sustain long-term program integrity improvements across delivery systems

Collectively, these efforts will enable Iowa Medicaid to meet the CMS mandate, stabilize long-term revalidation operations, reduce administrative burden, and reinforce the accuracy, integrity, and reliability of provider enrollment information across the program.

The Iowa Medicaid current provider revalidation process is predominantly manual and requires substantial administrative effort. The process relies on multiple state systems, contractor/vendor support, and federally mandated screening activities, creating a complex and resource intensive workflow.

Despite the manual processes Iowa Medicaid applies Medicare's risk-based screening categories, including adjustments for providers whose risk levels change after initial enrollment. Over the past year, Iowa Medicaid has implemented key improvements to strengthen data accuracy, screening, workflow automation, and staff readiness. This plan reflects the current operational model and assesses resource needs to support the statewide revalidation effort.

Iowa Medicaid identified key operational areas for improvement to strengthen provider enrollment and revalidation functions. These enhancement activities include data integrity, workflow automation, screening procedures and provider visibility. Ongoing and planned enhancements focus on modernization, risk-based triage, and expanded capacity to meet federal off-cycle revalidation requirements.

In alignment with Iowa Medicaid's efforts to strengthen program integrity and improve provider data quality, Iowa Medicaid submitted a Provider Advanced Planning Document (APD) to CMS in May 2026. This APD outlines the system enhancements, operational changes, and resource needs required to address the areas for improvement identified through recent reviews. These enhancements will support more efficient provider enrollment and monitoring processes, improve data accuracy, and increase the overall effectiveness of provider oversight activities.

## Strategic Goals and Objectives

This strategic plan outlines the current operational processes used by Iowa Medicaid and provides an overview of system enhancements and process improvements being implemented to address gaps and areas of concern. This plan will also assess the operational capacity required to support the increased workload associated with this effort. Iowa Medicaid has identified the following goals to address and improve compliance:

1. Modernizing the licensing workflows by automating verification, cleaning invalid data, enhancing reports, and eliminating manual processes for out-of-state providers will ensure compliance and reduces delays and errors in enrollment. This will require collaboration with information technology partners (IT), automated match updates, and standard operating procedure (SOP) revisions. We anticipate this improvement to be achieved over a six-month timeframe.

### Outcomes will be measured by:

- 90% reduction in invalid license entries
- 95% accuracy in expired-license reporting
- 90% automated deactivation of unmatched or expired licenses

### Licensing, Certification & Data Automation

Scope Includes:

- Combined expired-license items
  - License & certification system enhancements
  - Out-of-state provider license automation
  - Data cleanup + automated match processes for in-state providers
  - Adding Behavior Health provider type to automation
  - Enhanced reporting logic
2. Automation of Medicaid revalidation to ensure proper deactivation for overdue providers and establish the inactive provider rule. This will require provider training, communication and policy manual updates, and IT engagement for system updates. Leveraging Medicare screening during enrollment and revalidation will strengthen data integrity and reduce administrative backlog. We anticipate this improvement to be achieved over a nine-month timeframe.

This will be measured by:

- 80% reduction in expired revalidations
- 90% automation of CMS revalidation data ingestion
- 100% automated deactivations for missed revalidation deadlines

## **Revalidation, Deactivation & Provider Lifecycle Compliance**

Scope Includes:

- Revalidation alignment
  - Automation of deactivation for failure to revalidate
  - Inactive provider automation
  - Ensuring 5-year cycles and timely status updates
  - CMS data integration
3. Develop a centralized provider enrollment risk assessment tool that will leverage Provider Enrollment, Chain, and Ownership System (PECOS) and all other required Medicare screening components via an application programming interface (API). Utilize the risk assessment tool to centralize the screening and capture any providers bumped up throughout the enrollment cycle automatically. This requires system integration, permissions updates, and unified workflows and will enhance program integrity and standardize provider risk assessments. We anticipate this improvement to be deployed within six months and fully operational within 12 months.

This will be measured by:

- 75% reduction of manual screenings
- 100% of newly enrolled providers assigned a system-captured risk level
- Zero missed exclusion/sanction updates

## **Screening Modernization & Centralized Risk Oversight**

Scope Includes:

- Medicare screening leverage
  - Centralized screening platform for all checks
  - Risk-level capture at enrollment and revalidation
  - Ownership visibility & oversight enhancements
  - Expanded Program Integrity (PI) access for sanctions/exclusions updates
4. Modernize enrollment by digitizing applications, automating forms and letters, enabling electronic communication and requiring provider attestations. This will include system enhancements, electronic provider communication and workflow updates. This will reduce processing delays, increase provider satisfaction, and ensure consistent compliance communication. We anticipate this improvement to be made over 12 months.

This will be measured by:

- 100% transition to electronic applications
- 100% automation of provider-facing letters
- 70% of providers adopting electronic communication methods within year one

## **Provider Enrollment Process Modernization**

Scope Includes:

- Electronic provider applications
  - Provider attestations for updates (address, affiliations, ownership)
  - Updated forms and letters
  - Automated correspondence of notices
  - Electronic provider communication (email + SMS)
5. Strengthen financial controls by modernizing Electronic Funds Transfer (EFT), changing workflows and tightening system permissions. To achieve this, IT security updates, revised forms, and training will be required. This reduces exposure to financial fraud and improves provider trust in the agency. We anticipate full implementation within 120 days.

This will be measured by:

- 0 unauthorized EFT changes
- 100% of EFT changes verified through enhanced process
- 100% staff trained

## **Financial Security & EFT Control Enhancements**

Scope Includes:

- EFT process redesign
  - Split EFT letters
  - Iowa Medicaid Portal Access (IMPA) role/security review
  - Fraud prevention enhancements
6. Develop, deploy, and iteratively enhance an enterprise dashboard that provides real-time internal insights on FFS provider risk indicators. The dashboard will integrate multiple data sources and analytics components to display provider-level risk levels, ownership linkages, revalidation timelines, and location-based clustering patterns. This tool will support oversight activities, audit readiness, and proactive compliance monitoring.

The initial launch will occur within 6 months, followed by continuous enhancement for evolving oversight needs.

- Dashboard launched with at least 85% data completeness, with a plan for closing remaining gaps
- Monthly data refresh cycle implemented
- Ability to flag multi-provider locations

## **Provider Data Transparency & Analytics**

Scope Includes:

- Real-time FFS provider dashboard
- Visibility into risk level, provider type, location, revalidation data
- Ownership and shared-location visibility
- All-system data quality alignment

## **Strategy Scope**

The combined scope of work includes modernization and automation efforts across the full provider enrollment lifecycle, licensing verification, financial controls, screening processes, and data transparency systems. Key work components include updating and enhancing multiple IT systems, implementing automated workflows, improving data quality, and establishing centralized tools for oversight and compliance. Activities span licensing system enhancements, automated match processes, revalidation alignment, deactivation automation, centralized risk screening platform development, and digitization of provider applications and communications. Additional work includes redesigning EFT processes, security and role-based access updates, fraud prevention safeguards, development of real time provider dashboards, cross system data integration, and transparency improvements. This scope requires collaboration across IT, Program Integrity, Operations, Policy, Analytics, and Provider Relations teams to ensure consistent processes, accurate data, automation of high-volume tasks, and improved compliance throughout the provider lifecycle.

## Operational Framework

Iowa Medicaid will conduct a comprehensive revalidation process using a wave based, phased approach. This methodology is designed to distribute operational workload evenly, accelerate high-risk reviews, strengthen program integrity, and reduce the risk of provider disruption.

### This methodology focuses on:

- Prioritization of high-risk providers past due and atypical providers
- Overlapping waves will be issued approximately every 30 days
- Strict triage and monitoring protocols
- Integrated system checks and cross agency validation
- Accelerated enforcement actions for nonresponsive providers
- Continuous updates to provider directories and managed care partners

### Wave Based Approach:

- Revalidation notices will be issued in overlapping 30-day waves  
High-risk, providers past due for revalidation and atypical providers are prioritized in Phase 1, followed by all other enrolled providers in Phase 2
- Each wave is sequenced so the Provider Enrollment team begins processing one wave while issuing the next
- Providers will receive targeted outreach that includes email reminders, updated notice templates, and clear instructions for required actions
- System indicators will be centrally tracked and monitored

### Screening Methodology:

- Standard federal and state screenings
- High-risk site visits and background checks when required
- Escalation to Program Integrity for any anomalies or concerns
- Verification of ownership and control disclosures
- Cross system data verification and consistency checks

### Documentation and Intake Workflow:

- All revalidation packets are processed through workflow queues, including prescreening, role assignments, and multiple systems that require updates for specific provider types

## Stakeholder Engagement and Communication

A statewide revalidation effort of this scale requires coordinated, timely communication and clear guidance for providers, managed care partners, stakeholders, and internal staff. Iowa Medicaid will implement a streamlined communication and training strategy to ensure all parties understand requirements, timelines, expectations, and operational impacts.

### Communication Plan

Iowa Medicaid will launch a multi-channel outreach campaign to ensure providers receive early notice and consistent direction throughout the revalidation effort. Iowa Medicaid is committed to transparency and will continue to update the public on the status of our provider revalidation efforts.

#### Key activities include:

- Statewide announcements explaining CMS requirements, timelines, and expectations for high-risk and full-population revalidation
- Updated, standardized revalidation notices templates with clear instructions, required documentation, and consequences for non-response
- Targeted outreach to high-risk, atypical, and historically non-responsive providers
- Provider bulletins, website updates, and step-by-step instructions to guide completion
- Email notifications, IMPA secure messages, and wave-specific reminders

#### Transition to State Print Services:

To support high-volume mailings, all revalidation notices will be printed and distributed through State Print Services. This transition will:

- Replace manual printing and assembly
- Improve accuracy and ensure timely, wave-based distribution
- Reduce administrative burden and support standardized formats

#### Managed Care Plan Communication:

Managed Care Plans will receive advance notice and operational guidance for each wave, including:

- Provider lists and follow-up required actions
- Instructions for updating directories and systems to reflect enrollment status changes
- Templates for communicating requirements to network providers
- Regular reconciliation updates to maintain alignment between state and MCO systems

**Internal Communication and Staff Readiness:**

Iowa Medicaid will prepare staff and contractors through coordinated operations, internal communication and targeted training. Before each wave, internal teams will receive:

- Updated SOPs and process documentation
- Clarified roles for intake, triage, screening, and enforcement
- Overviews of system enhancements such as automated validations and discrepancy reporting
- Caseload projections and wave timelines
- Briefings for Provider Enrollment, Program Integrity, and contractor staff

**Staff Training:**

These training courses will focus on:

- End to end revalidation workflows
- Required documentation and common provider errors
- Federal and state screening procedures
- System navigation
- Escalation pathways for high-risk, incomplete, or suspicious submissions
- Customer service expectations, including call-center scripts and support materials

**Provider Support and Outreach Tools:**

Iowa Medicaid will equip providers with accessible, easy-to-use support resources, including:

- Quick reference guides and FAQs
- Step-by-step submission instructions
- Recorded webinars and short instructional videos
- A dedicated inbox or ticketing system for inquiries
- Updated call-center scripts tailored to each wave

**Call Center and Help Desk Support:**

To manage increased inquiry volume, Iowa Medicaid will:

- Expand call-center staffing during peak periods
- Implement standardized triage and escalation workflows
- Provide representatives with wave-aligned scripts and materials
- Track call themes to inform future communications

**Outcome Reporting and Continuous Improvement:**

Iowa Medicaid will monitor communication effectiveness and refine strategies as needed by:

- Publishing public dashboard updates on revalidation progress and outcomes
- Conducting post-wave reviews to identify improvements
- Updating communication materials and training resources as policies or systems change

# Phase 1: Swift High-Risk Provider Revalidation

## **Timeline: Beginning July 1, 2026 (State Fiscal Year 2027)**

To manage this significant increase in workload, Iowa Medicaid will transition to a controlled, wave-based method of issuing revalidation notifications. Rather than issuing notices to the entire provider population at once, the state will send notices in overlapping waves beginning with high-risk providers, followed by those already past due, and concluding with all other providers. Each wave will provide approximately 30 days for providers to complete their revalidation before the next wave is sent. This strategy will allow the Provider Enrollment team to begin processing the first wave as the second wave is dispatched, ensuring steady workflow and preventing bottlenecks. Phase 1 activities will launch at the start of State Fiscal Year 2027 on July 1, 2026, and continue through the remainder of the fiscal year. The implementation will follow the timelines referenced in Table 1 below followed by the launch of overlapping waves spanning 24 months.

## **Providers Subject to Revalidation:**

- Providers who are assigned an atypical NPI
- Past due providers for revalidation
- Providers who had dropped to moderate risk after initial enrollment. (Home Health, DME, Hospice)
- All Provider types have been escalated to high-risk due to risk indicator. (Including but not limited to: Behavior Analyst (BA) and Home and Community Based Service (HCBS) providers, which are generally limited risk but will be prioritized based on risk indicators

## **Risk indicators:**

- Providers that have had a payment suspension
- Providers that have received overpayment
- Providers that have been excluded by OIG in the past 10 years
- Providers that are enrolling after a lift of a moratorium

**Table 1**

<b>Key Action for Success</b>	<b>Timeline</b>
Issue revalidation notices – first wave	Q1
Issue notices for atypical to NPI transition	Q1
Begin intake, triage and monitoring of response rate	Q1
Conduct screening of all completed revalidation	Q2
Identify non-responsive providers	Q2
Escalate non-responsive providers to Program Integrity	Q2
Enforcement of atypical to NPI transition	Q2
Issue revalidation notices – second wave	Q2
Initiate corrective actions or administrative steps (e.g., suspension deactivation review) for nonresponsive or high-concern providers	Q2
Monitor updates to provider directories and MCO partner systems as statuses change	Q4
Ensure data cleanup, segmentation and verification across systems and contractor directories	Q4
Conclude 100% of all high-risk revalidations	Q4
Continuous monitoring of updates to provider directories and MCO partner systems as statuses change	Ongoing

## Providers Subject to Revalidation – Phase 1

**Source:** Medicaid Provider Data

**Notes:** This table consists of the list of providers with state-issued atypical NPIs; Providers that are past due for revalidation. It includes all provider types as enrolled, according to the Provider Tax ID.

Provider Tax IDs may be enrolled as more than one provider type, so the sum of Tax IDs by provider type will be inflated, as a single Tax ID may appear across multiple provider categories.

The above information also applies to NPIs.

Highlighted rows represent providers that are moderate or high risk at initial enrollment. These records are only included in the row that includes atypical NPI providers or providers that are past due for revalidation. These Tax IDs are not included in subsequent phase 1 categories.

Provider Type	Description	Distinct Count – Tax ID Enrollments	Distinct Count – NPI Enrollments
1	General Hospital	587	756
2	Physician MD	2899	26788
3	Physician DO	847	3739
4	Dentist	613	1870
5	Podiatrist	180	420
6	Optometrist	235	769
7	Optician	17	84
8	Pharmacy	245	894
9	Home Health Agency	89	107
10	Independent Lab	93	149
11	Ambulance	281	312
12	Medical Supplies	220	431
13	Rural Health Clinic	98	275
14	Clinic	18	38
15	Physical Therapist	175	2089
16	Chiropractor	573	1177
17	Audiologist	82	315
18	Skilled Nursing Facility	94	105
19	Rehab Agency	41	97
20	Intermediate Care Facility	218	282
21	Community MH	25	32
22	Family Planning	13	15
23	Residential Care Facility	37	42
24	Health Maintenance Organ	2	31
25	IC ID State	2	2
26	Mental Hospital	9	9
27	Community-Based ICF/ID	20	63
29	Psychologist	201	766
30	Screening Center	17	19
31	Hearing AID Dealer	15	34

32	Occupational Therapist	122	829
34	Orthopedic Shoe Dealer	1	1
35	Maternal Health Center	17	17
36	Ambulatory Surgical Center	33	33
38	Certified Nurse Midwife	88	285
39	Birth Center	1	1
40	Area Education Agency	4	4
41	Psych Medical Inst Children	24	27
42	MEP Case Manager	6	6
44	CRNA	220	2398
45	Hospice	43	59
48	Clinical Social Worker	320	1070
49	Federal QUAL Health Center	20	104
50	Nurse Practitioner	1082	10460
52	Nursing Facility – INT Disable	1	1
55	Lead Inspection Agencies	13	13
56	Local Education Agency	81	81
57	Infant Toddler Providers	4	4
58	PACE	2	2
59	Indian Health Service	1	1
60	Institutional - General	3	3
61	Other Practitioner – General	11	17
62	Behavioral Health	837	4299
63	Behavioral Health Intervention -SVC	88	89
64	Habilitation Services	129	148
65	NEMT Broker	1	1
66	Electronic Health Incentive	1	1
67	Assertive Community Treatment	6	7
68	Physician Assistant	2045	3913
69	Independent Speech Pathologist	83	449
72	Public Health Agencies	44	49
73	SPMI SED Provider	1	1
75	IHAWP QHP Provider	2	198
76	Accountable Care Organizations	1	1
78	Neurological Rehab Facility	1	1
80	Crisis Response Services	29	32
81	Subacute Mental Health Service	7	7
82	Pharmacist	102	1406
88	Certified Community Behavior Health Clinic (CCBHC)	10	10
99	Waiver	588	727
<b>Distinct Tax ID Total</b>		<b>9,350</b>	<b>64,286</b>

# Phase 2: Revalidation of All Other Providers

## Timeline: State Fiscal Year July 1, 2027, through June 30, 2028

### Providers Subject to Revalidation:

- All other providers enrolled with Iowa Medicaid

**Table 2**

Key Action for Success	Timeline
Issue revalidation notices – third wave	Q1
Begin intake, triage, and monitoring of response rate	Q1
Conduct screening of all completed revalidations	Q2
Identify non-responsive providers	Q2
Escalate non-responsive providers to Program Integrity	Q2
Conclude 85% of all revalidations	Q2
Initiate corrective actions or administrative steps (e.g., suspension, deactivation review) for nonresponsive or high-concern providers	Q3
Monitor updates to provider directories and MCO partner systems as statuses change	Q3
Conclude 100% of all revalidations	Q4
Conclude corrective actions or administrative steps (e.g., suspension, deactivation review) for nonresponsive or high-concern providers	Q4
Continuous monitoring of updates to provider directories and MCO partner systems as statuses change	Q4
A close-out phase will follow to finalize reporting and ensure compliance	Q4

## Risk Management and Mitigation

Risk Area	Description at Risk	Mitigation Strategy
<b>Provider Enrollment (PE) workload strain</b>	High revalidation may overwhelm PE capacity and delay processing.	Use overlapping waves, expand staffing via contract amendments, apply triage using the risk-assessment tool, and increase automation.
<b>Inaccurate provider contact information</b>	Incorrect data could delay notices and reduce provider responsiveness.	Deploy address-validation tools, improve email accuracy.
<b>Provider non-responsiveness or complaints</b>	Some providers may miss deadlines or dispute requirements.	Targeted outreach for providers, clear communication, and timely escalation to Program Integrity.
<b>Delays in system enhancements</b>	Required MMIS/NPPES upgrades may lag operational needs.	Prioritize auto-deactivation, dashboards, and synchronization improvements.
<b>Limited site-visit capacity</b>	High-risk providers requiring site visits may exceed available resources.	Reassess staffing and vendor capacity.
<b>Two-year federal revalidation mandate</b>	Full revalidation of all providers within two years – exceeding historical volume.	Implement wave-based scheduling; use Medicare screening substitutions for dual-enrolled providers.
<b>Large statewide workload</b>	Implement monthly capacity model; automate screening.	Implement monthly capacity model; automate screening; triage low-risk cases; expand staffing.
<b>Insufficient automation across systems</b>	Manual processes increase delays and error risks.	Enhance system automation, deploy dashboards, and centralize screening via APIs.
<b>Screening workload inefficiencies</b>	Manual processes increase delays and error risks.	Use risk assessment tool; automate checks; use Medicare screening for dual providers; centralize screening resources.
<b>Enforcement and compliance clarity</b>	Need clearer deactivation timing and enforcement under 42 CFR 455.416.	Define enforcement and appeal processes; implement auto-deactivation.
<b>Directory accuracy and system alignment</b>	Provider status changes may not be consistently reflected across FFS and MCO directories.	Continuous directory updates; segmentation and verification.
<b>Communication gaps</b>	Ineffective communication may reduce provider responsiveness.	General notice campaign; updated revalidation letters.

## Cost Considerations

Completing a statewide revalidation effort within a two-year period will generate both direct and indirect planning costs. Direct costs will include system modifications, printing and postage, and expanded contractor staffing to manage the increased volume of revalidation activities. Indirect costs will include temporary staffing, increased call center demand, returned mail processing, and the need for additional staff training. Some of these costs are expected to be partially offset by efficiencies achieved through recent data quality improvement initiatives. The APD request submitted to CMS reflects anticipated direct costs, as well as the projected operational savings associated with more accurate provider data and streamlined revalidation processes.

## Monitoring, Reporting, and Quality Assurance

This two-year strategy outlines Iowa Medicaid's structured approach for meeting CMS's revalidation mandate while reinforcing program integrity, operational consistency, and the continuity of provider participation. Over the next 24 months, Iowa Medicaid will advance a coordinated, data-driven oversight model that provides clear visibility into progress, risks, and system performance.

### Strategic Oversight Priorities (24-Month):

- Complete high-risk and full-population revalidations using a phased, wave-based model
- Transition atypical providers to NPIs and increase provider data accuracy
- Expand automation across enrollment systems and screenings to reduce manual workload
- Strengthening oversight through enhanced screening, monitoring, and Program Integrity coordination
- Improve directory accuracy and maintain alignment across delivery systems, including MCOs
- Build sustainable operational capacity through updated procedures, staffing adjustments, and system modernization

Collectively, these activities will position Iowa Medicaid to meet federal requirements, reduce program-integrity risk, and maintain a stable, efficient revalidation process.

## Metrics to Measure Program Integrity Strategy

Iowa Medicaid will apply consistent, quantifiable metrics which could include tracking progress, identifying risks, and ensuring compliance with federal expectations. Metrics will inform internal decision-making and, where appropriate, be incorporated into public-facing dashboards.

### Core Metrics:

- Revalidation completion rates: high-risk and statewide
- Percent of high-risk providers revalidated each quarter
- Percent of full provider population revalidated each quarter

### Response and Participation Metrics:

- Provider responsiveness by wave (30-day return rates)
- Atypical-to-NPI transition compliance rates

### Screening Outcomes:

- Number of providers flagged in federal and state screening systems
- Number of cases referred to Program Integrity and associated outcomes

### Operational Throughput Metrics:

- Average time from notice issuance to case completion
- Processing times by provider type and risk category

### Data Accuracy Metrics:

- Rate of resolved discrepancies identified in weekly automated data-quality reports

### Enforcement Metrics

- Suspensions, deactivations, or administrative actions for non-responsive providers
- Public Dashboard Indicators (as referenced in the Operational Framework)

### Statewide Revalidation Progress

- Atypical-to-NPI transition progress
- Provider directory accuracy indicators
- Screening and Program Integrity outcomes

## Verification of Provider Information

Iowa Medicaid will continue to strengthen and automate verification activities to ensure provider data remains accurate throughout the revalidation period and beyond.

### Ongoing Verification Activities:

- Monthly automated checks to comply with 42 CFR 455.Subpart E
- Annual provider attestation to confirm or update data
- Automated system validation rules for addresses, credentials, identifiers
- Centralized discrepancy reporting with weekly discrepancy reports
- Targeted outreach to resolve missing or incorrect information
- Corrective action workflows with escalation to Program Integrity as needed

### Enhancements Underway:

- Data-flow integration to strengthen synchronization
- Deployment of address-validation tools for improved contact accuracy
- Modernization of the revalidation notice process (including use of Print Services)

## Consistency and Accuracy of Provider Data Across FFS and MCO Delivery Systems

Iowa Medicaid maintains strict alignment between its systems and MCO provider directories to ensure accurate, timely provider status, service location, specialty, and network information.

### Alignment Activities:

- Enforce MCO compliance with state directory-accuracy standards
- Identify inconsistencies (e.g., service locations, NPIs, taxonomy codes) using automated and manual reviews
- Require MCOs to correct discrepancies within defined contractual timeframes
- Use continuous monitoring to ensure status changes (e.g., suspensions, deactivations) propagate across MCO directories
- Conduct periodic sampling audits of MCO network accuracy

## Coordination with Law Enforcement Partners

Iowa Medicaid collaborates closely with state and federal enforcement agencies to ensure robust detection, escalation, and resolution of compliance concerns identified during revalidation and ongoing screening.

### Key Coordination Partners:

- Medicaid Fraud Control Unit (MFCU): Receives referrals related to suspected fraud, falsified credentials, or non-compliance
- Center for Program Integrity (CPI): Ensures alignment with federal expectations and cross-state data sharing
- HHS-Office of Inspector General (OIG): Supports exclusion checks and investigative activities
- Department of Justice (DOJ): Engages on cases with potential criminal misconduct
- State Licensing Boards & Secretary of State: Validates licensure, business registrations, and sanction histories

### Escalation Pathways:

- High-risk or concerning cases are first reviewed by Program Integrity (PI)
- PI determines whether referrals should be sent to MFCU or federal partners
- Enrollment holds, suspensions, or terminations are implemented in accordance with 42 CFR 455.416

### Outcome Tracking:

- Iowa Medicaid will track number of referrals, violation types, and resulting actions
- Quarterly trend analysis will inform updates to screening rules, risk tiers, and wave sequencing

## Conclusion and Commitment

Iowa Medicaid is committed to carrying out this two-year revalidation initiative with clarity, consistency, and accountability. Through strengthened communication, rigorous monitoring, enhanced system alignment, and transparency, Iowa Medicaid will ensure the provider community has the tools and support needed to successfully complete revalidation while maintaining uninterrupted access to care for members.

### **Iowa Medicaid reaffirms its commitment to:**

- Meeting all federal CMS requirements and timelines
- Maintaining accurate, reliable provider data across delivery systems
- Supporting providers with clear guidance and responsive assistance
- Upholding strong program integrity standards through consistent oversight
- Continuously improving processes based on data, feedback, and operational lessons learned

By executing this plan with diligence and transparency, Iowa Medicaid will establish a durable, efficient revalidation framework that strengthens the foundation of the provider network and ensures public confidence that taxpayer dollars are going to legitimate service providers.