Quality Improvement Strategy

(Describe the state's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *(Analysis and Aggregation)*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	SP-1 Number and percent of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals Numerator: # of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals Denominator: # of reviewed service plans	Member service plans are reviewed at a 95% confidence level with +/- 5% margin of error on a three-year cycle. Data is inductively analyzed and reported to the state.	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	The MCO ensures that the Case Manager, Community-based Case Manager, or Integrated Health Home Care Coordinator has addressed the member's health and safety needs in the member's service or treatment plan. The Medical Services Unit completes a quality assurance desk review of member service plans within 10 days of receipt. The Medical Services Unit sends review results, notification of any deficiency, and expectations for remediation to Contracted Entity (Including MCOs) within 2 business days of completing the review. The Contracted Entity (Including MCOs) addresses any deficiencies with the provider, Case Manager, or Integrated Health Home and target training and technical assistance to those	Data is Aggregated and Analyzed Continuously and Ongoing

					deficiencies. General methods for problem correction at a systemic level include informational letters, provider training, and collaboration with stakeholders and changes in policy.	
	SP-2 Number and percent of service plans which were revised when warranted by a change in the member's needs. Numerator: # of service plans which were revised when warranted by a change in the member's needs. Denominator: # of service plans reviewed that required a revision due to a change in the member's needs. (# of statistically valid service plan reviews required for each waiver - data reported separately for each waiver)	Member service plans are reviewed at a 95% confidence level with +/- 5% margin of error on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

	SP-3: Number and percent of service plans which are updated on or before the member's annual due date. Numerator: # of service plans which were updated on or before the member's annual due date; Denominator: # of service plans due for annual update that were reviewed.	Member service plans are reviewed at a 95% confidence level with +/- 5% margin of error on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

	SP-4 Number and percent of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan. Numerator: # of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan. Denominator: # of member's service plans reviewed	Member service plans are reviewed at a 95% confidence level +/- 5% margin of error on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

	SP-5: Number and percent of members from the HCBS IPES who responded that they had a choice of services. Numerator: # of HCBS IPES respondents who responded that they had a choice of services; Denominator: # of HCBS IPES respondents that answered the question asking if they had a choice of services.	Member service plans are reviewed at a 95% with +/- 5% margin of error confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

	SP-6: Number and percent of service plans from the HCBS QA survey review that indicated the member had a choice of providers NUMERATOR: The total number of service plans reviewed which demonstrate choice of HCBS service providers "Demonstrate choice" refers to documentation located within the reviewed service plan that indicates the member was given a choice of HCBS service providers. DENOMINATOR: The total number of service plans reviewed	Member service plans are reviewed at a 95% confidence level with +/- 5% margin of error on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

Providers meet required qualifications.	QP-1: Number and percent of licensed or certification Habilitation provider enrollment applications verified against the appropriate licensing and/or certification entity NUMERATOR: Number of providers verified against appropriate licensing and/or certification entity prior to providing services. Note: The entire population is captured in this measure. All providers new and current will be evaluated during this process. DENOMINATOR: Number of licensed or certified Habilitation providers	Sampling Size: 100%	Contracted Entity (Including MCOs)	Data is Collected Monthly	Contracted Entities (Including MCOs) manage the provider networks and do not enroll providers who cannot meet the required qualifications. If it is discovered by the Provider Services unit or MCO during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, they are required to correct the deficiency prior to enrollment or reenrollment approval. Until they make these corrections, they are ineligible to provide services to members. If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders, and changes in policy.	Data is Aggregated and Analyzed Quarterly

	QP-2: Number and percent of providers, specific by Habilitation service, that meet training requirements as outlined in State regulations. NUMERATOR: Number of reviewed HCBS Habilitation providers which did not have a corrective action plan issued related to training DENOMINATOR: Number of HCBS Habilitation providers that had a certification or periodic quality assurance review	Sample Size: 100%	Contracted Entity (Including MCOs)	Data is Collected monthly and quarterly	See QP-1 Above	Data is Aggregated and Analyzed Quarterly
	QP-3: Number and percent of non-licensed/ noncertified providers that met Habilitation requirements prior to direct service delivery	Sampling Size: 100%	Contracted Entity (Including MCOs)	Data is Collected monthly and quarterly	See QP-1 Above	Data is Aggregated and Analyzed Quarterly

	NUMERATOR: Number of non-licensed/noncertified providers who met Habilitation requirements prior to service delivery DENOMINATOR: Number of non-licensed/noncertified enrolled providers					

Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).	SR-1: Number and percent of service plans which indicate that the member resides in a setting that meets the HCB setting requirements. NUMERATOR: The total number of service plans reviewed which indicate that the member resides in a setting that meets the HCB setting requirements. DENOMINATOR: The total number of service plans reviewed	Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level with +/- 5% margin of error on a three-year cycle.	Contracted Entity (Including MCOs)	Data is Collected Continuously and Ongoing	Contracted Entities (Including MCOs) ensure that Case Managers or Integrated Health Home Care Coordinators have addressed the member's health and safety risks during service authorization. The Iowa Medicaid Medical Services Unit completes the QA Service Plan Desk Review within 10 days of receipt of the information from the member's HCB service provider(s) and the Case Manager or IHH Care Coordinator. The Iowa Medicaid Medical Services Unit will send the review results to the MCO and the Case Manager or Integrated Health Home Coordinator within 2 business days of completing the review.	Data is Aggregated and Analyzed Quarterly
	SR-2: Number and percent of service plans which indicate that the member is receiving services in a setting that meets the HCB setting requirements. NUMERATOR:	Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level with +/- 5% margin of error on a three-year cycle.	Contracted Entity (Including MCOs)	Data is Collected Continuously and Ongoing	Contracted Entities (Including MCOs) ensure that Case Managers or Integrated Health Home Care Coordinators have addressed the member's health and safety risks during service authorization. The Iowa Medicaid Medical Services Unit completes the QA Service Plan Desk Review within 10 days of	Data is Aggregated and Analyzed Quarterly

	The total number of service plans reviewed which indicate that the member is receiving services in a setting that meets the HCB setting requirements DENOMINATOR: The total number of service plans reviewed				receipt of the information from the member's HCB service provider(s) and the Case Manager or IHH Care Coordinator. The Iowa Medicaid Medical Services Unit will send the review results to the MCO and the Case Manager or Integrated Health Home Coordinator within 2 business days of completing the review.	
The SMA retains authority and responsibility for program operations and oversight.	AA-1: Number and percent of required MCO HCBS PM Quarterly reports that are submitted timely NUMERATOR: Number of MCO HCBS PM Quarterly reports submitted timely. DENOMINATOR: Number of MCO HCBS PM Quarterly reports due in a calendar quarter.	Contracted Entity and MCO performance monitoring. Sampling: 100% Review	Contracted Entity (Including MCOs)	Data is Collected Monthly	Each operating agency within Iowa Medicaid is assigned state staff to serve as a contract manager. This position oversees the quality and timeliness of monthly scorecards and quarterly contract reports. Further, Iowa Medicaid holds a monthly manager meeting in which the account managers of each contracted unit present the operational and performance issues discovered and remediated within the past month. This allows all state staff to collectively sustain transparent administrative oversight. If the contract manager, or policy staff, discovers and documents a	Data is Aggregated and Analyzed Quarterly

					repeated deficiency in performance of the contracted unit, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of invoiced payment compensation.	
	AA-2: Number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures NUMERATOR: Number of months each MCO entered all required HCBS PM data; Denominator = Number of reportable HCBS PM months in a calendar quarter.	Contracted Entity performance monitoring. Sampling: 100% Review	Contracted Entity	Data is Collected Quarterly	See AA-1 Above	Data is Aggregated and Analyzed Quarterly

The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	FA-1: Number and percent of FFS reviewed paid claims supported by provider documentation NUMERATOR: Number of FFS reviewed paid claims supported by provider documentation DENOMINATOR: Number of reviewed paid claims	Program Integrity Unit Sampling: 95% confidence level with +/- 5% margin of error	Contracted Entity (Including MCOs)	Data is Collected Quarterly	Program Integrity reviews claims and evaluates whether there was supporting documentation to validate the claim. The Managed Care Organizations will evaluate their claims. When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped, and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments, require screening of all claims, referral to MFCU, or provider suspension. The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a monthly and quarterly basis.	Data is Aggregated and Analyzed Quarterly
	FA-2: Number and percent of clean claims that are paid by the managed care organizations within the timeframes	The Program Integrity (PI) unit Sampling: 95% confidence level with +/- 5% margin of	Contracted Entity (Including MCOs)	Data is Collected Quarterly	See FA-1 Above	Data is Aggregated and Analyzed Quarterly

	specified in the contract NUMERATOR: Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract DENOMINATOR: Number of Managed Care provider claims	error				
	FA-3: Number and percent of claims that are reimbursed according to the Iowa Administrative Code-approved rate methodology for the services provided NUMERATOR: Number of reviewed paid claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for the services provided	Program Integrity Unit SAMPLING: 100% Sample	Contracted Entity (Including MCOs)	Data is Collected Monthly	See FA-1 Above	Data is Aggregated and Analyzed Quarterly

	DENOMINATOR: Number of reviewed paid claims					
	FA-4 Number and percent of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology NUMERATOR: Number of Capitation payments made to the MCOs at the approved rates through the CMS certified MMIS. DENOMINATOR: Number of capitation payments made through the CMS certified MMIS	HCBS QIO SAMPLING: 100% Sample	Contracted Entity	Data is Collected Monthly	Iowa Medicaid Data Warehouse will pull data quarterly. Core will review the capitation payments on a monthly basis and ensure that the capitation amount paid is the approved CMS rate.	Data is aggregated and analyzed Quarterly

The state identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	HW-1: Number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated as required NUMERATOR: Number of IAC-defined major critical incidents requiring follow-up escalation that were investigated as required; DENOMINATOR: Number of IAC-defined major critical incidents requiring follow-up escalation.	MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist. This data on incidents is inductively analyzed at 100%.	Contracted Entity (Including MCOs)	Data is Collected Monthly, Quarterly, and Annually	The HCBS Incident Reporting Specialist analyzes data for individual and systemic issues. Individual issues require communication with the service worker, case manager, IHH coordinator or MCO community-based case manager to document all efforts to remediate risk or concern. A follow-up escalation for an FFS or MCO member requires an FFS/MCO request to the provider for additional information if warranted by a CIR submission. If the additional research demonstrates a deficiency within provider policy or procedure, the FFS or MCO will open a targeted review to assist in remediation If these efforts are not successful, the IR Specialist continues efforts to communicate with the service worker, case manager, IHH coordinator or MCO community-based case manager their supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports. The HCBS Specialists conducting interviews conduct individual remediation to flagged	Data is Aggregated and Analyzed Quarterly

					questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the service worker, case manager, IHH coordinator or MCO community-based case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders, and changes in policy. In addition, Contracted Entities (including MCOs) initiate a quality-of-care review of all known adverse incidents involving a member who is receiving services or having care managed by the contractor. When contractor staff becomes aware of an adverse incident the incident is communicated to medical directors and/or compliance staff. If deemed high-risk the compliance staff requests recourse from the	

					service provider and the incident is communicated to clinical leadership within 24 hours. Within 5 business days the contractor's legal department is required to review the case to determine if an incident review is required. A full audit of the incident must be completed within 15 days. The contractor must then submit the incident report data to the Iowa Medicaid, HCBS Quality Assurance Manager. The Iowa Medicaid HCBS Quality Assurance Committee will review the data quarterly and address any trends requiring additional follow-up with the contractor.	
	HW-2: Number and percent of CIRs including alleged abuse, neglect, exploitation, or unexplained death that were followed up on as required NUMERATOR: Number of CIRs including a report of alleged abuse, neglect, exploitation, or unexplained death	MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist SAMPLING: 100%	Contracted Entity (Including MCOs)	Data is Collected Monthly, Quarterly, and Annually	See HW-1 Above	Data is Aggregated and Analyzed Quarterly

	that were followed up on as required DENOMINATOR: Number of CIRs that identified a reportable event of abuse, neglect, exploitation, and/or unexplained death					
	HW-3: Number and percent of members who received information on how to report abuse, neglect, exploitation and unexplained deaths NUMERATOR: Number of members service plans that indicate the members received information on how to report abuse, neglect, exploitation and unexplained deaths DENOMINATOR: Total number of member service plans reviewed	MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist Sampling: 100%	Contracted Entity (Including MCOs)	Data is Collected Monthly, Quarterly, and Annually	See HW-1 Above	Data is Aggregated and Analyzed Quarterly

	HW-4: Number and percent of unresolved critical incidents that resulted in a targeted review that were appropriately resolved. NUMERATOR: Number of unresolved critical incidents that resulted in a targeted review that were appropriately resolved; DENOMINATOR: Number of unresolved critical incidents that resulted in a targeted review.	MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist Sampling size: 100%	Contracted Entity (Including MCOs)	Data is Collected Monthly, Quarterly, and Annually	See HW-1 Above	Data is Aggregated and Analyzed Quarterly
	HW-5: Number and percent of critical incidents where root cause was identified NUMERATOR: Number of critical incidents where root cause was identified	MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist Sampling size: 100%	Contracted Entity (Including MCOs)	Data is Collected Monthly, Quarterly, and Annually	See HW-1 Above	Data is Aggregated and Analyzed Quarterly

	DENOMINATOR: Number of critical incident reports					
	HW-6: Number and percent of reviewed providers with policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written NUMERATOR: Number of providers reviewed that have policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written DENOMINATOR: Total number of providers reviewed	HCBS QIO Onsite QA review process Sampling size: 95% confidence level with +/- 5% margin of error	Contracted Entity	Data is Collected Monthly, Quarterly, and Annually	A representative sample of member case manager/care coordinators service plans, provider service plans and documentation will be reviewed to identify the existence of Behavioral Support Plans for any restrictive interventions Policies for restrictive measures include restraint, seclusion, restrictive interventions, behavioral interventions and behavioral management plans. The Quality Assurance Review ensures that providers are following State and Federal rules and regulations. In areas where a provider is determined to not be following State and Federal rules and Regulations a corrective action plan is issued to bring them into compliance. Providers issued a Probational Certification may be counted twice, depending upon review cycles.	Data is Aggregated and Analyzed Quarterly

	HW-7: Number and percent of Quality Assurance reviews where the provider did not receive a corrective action plan. NUMERATOR: Number of Quality Assurance reviews that did not receive a corrective action plan DENOMINATOR: Number of provider Quality Assurance Reviews completed	HCBS QIO Provider Quality Assurance Reviews Sampling size 100%	Contracted Entity	Data is Collected Monthly	The Quality Assurance Review ensures that providers are following State and Federal rules and regulations. In areas where a provider is determined to not be following State and Federal rules and Regulations a corrective action plan is issued to bring them into compliance. Providers issued a Probational Certification may be counted twice, depending upon review cycles.	Data is Aggregated and Analyzed Quarterly
	HW-8 Number and percent of emergency room visits that meet the definition of a CI where a CIR was submitted. NUMERATOR: Number emergency room visits, that meet the definition of a CI, where a CIR was submitted;					

	DENOMINATOR: Number of emergency room visits meeting the definition of CI.					
	HW-8 Number and percentage of Habilitation members who received care from a primary care physician in the last 12 months. NUMERATOR: Number of Habilitation members who received care from a primary care physician in the last 12 months; DENOMINATOR: Number of Habilitation members reviewed.					
An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that	LC-1: Number and percent of new referrals who had an evaluation indicating the individual 1915(i) eligible prior to receipt of services. NUMERATOR: Number of	IoWANS and MQUIDS MCO – PCP history system Sample Size: 95% confidence level with +/- 5% margin of error	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is collected quarterly	The data informing this performance measure is pulled from IoWANS and MCO data. The state's Medical Services Unit performs internal quality reviews of initial and annual 1915(i) eligibility determinations to ensure that the proper criteria are applied. In instances when it is discovered that this	Data is Aggregated and Analyzed Quarterly

1915(i) services may be needed in the future.	completed needs based eligibility determinations (initial) DENOMINATOR: Number of referrals for needs-based eligibility determination (initial)				has not occurred the unit recommends that the service worker take steps to initiate a new 1915(i) eligibility determination through communication with the member and physician. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.	
The 1915(i) eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.	LC-2: Number and percent of members who have a 1915(i)-eligibility determination completed within 12 months of their initial evaluation or last annual reevaluation. NUMERATOR: Number of completed 1915(i)-eligibility determinations DENOMINATOR: Number of referrals for needs-based eligibility review	FFS – IoWANS and MQUIDS MCO – PCP history system Sample Size: 95% confidence level with +/- 5% margin of error	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is collected quarterly	See LC-1 above.	Data is Aggregated and Analyzed Quarterly

The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.	LC-3: Number and percent of initial needs-based eligibility decisions that were accurately determined by applying the approved needs-based eligibility criterion using standard operating procedures NUMERATOR: Number of needs-based eligibility decisions that were accurately determined by applying the correct criteria DENOMINATOR: Number of reviewed needs-based eligibility determinations.	Sampling Size: 95% confidence level with +/- 5% margin of error	State Medicaid Agency & Contracted Entity (Including MCOs	Data is collected quarterly	See LC-1 above.	Data is Aggregated and Analyzed Quarterly

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes

The State QA/QI system, at a minimum, addresses the following items: (1) health and safety issues of members receiving HCBS services; (2) abuse/neglect/ exploitation of members; (3) member access to services; (4) plan of care discrepancies; (5) availability of services; (6) complaints of service delivery; (7) training of providers, case managers, and other stakeholders; (8) emergency procedures; (9) provider qualifications; and (10) member choice.	Iowa Medicaid is the single state agency that retains administrative authority of Iowa's HCBS services. Iowa remains highly committed to continually improve the quality of services for all HCBS programs. The QIS developed by Iowa stratifies all HCBS services, including the State's 1915(c) waivers and 1915(i) state plan services. Data is derived from a variety of sources including the MCOs, HCBS Provider Quality Oversight databases, site reviews, follow-up compliance reviews, compliant investigations, evaluation reports, member satisfaction surveys, member interviews, and member records.	Data is Collected Continuously and Ongoing	Iowa Medicaid reviews the State QIS system no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that must involve all stakeholders in the system. Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often than annually due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities. Iowa Medicaid employs a Quality Assurance Manager to oversee data compilation and remediation activities. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to

			implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the HHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle. Based on contract oversight and performance measure implementation, Iowa Medicaid holds weekly policy staff and long-term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers monthly to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. Data from QA/QI activities are also presented to the HCBS QA/AI Committee on a quarterly basis. The QA/QI Committee reviews the data

			makes recommendations for changes in policy to the Iowa Medicaid Policy staff and Bureau Chief. The Committee also uses this information to direct HCBS Provider Quality Oversight Specialists to provide training, technical assistance, or other activity. The Committee monitors training and technical assistance activities to assure consistent implementation statewide. The Committee also directs workgroups on specific activities of quality improvement and other workgroups are activated as needed. The Committee is made up of certain HCBS Provider Quality Oversight staff and supervisors, and Iowa Medicaid Policy staff. Minutes are taken at each of the meetings, which show evidence that analysis of data is completed and recommendations for remediation and system improvements are made. Finally, Iowa Medicaid analyzes general system performance through the management of contract performance benchmarks, IoWANS reports, and Medicaid Value Management reports and then works with contractors, providers, and other agencies regarding specific issues. HCBS Annual Reports are sent to the Iowa Association of Community Care Providers. Reports are also available to agencies, waiver providers, participants, families, and other interested parties upon request.

In accordance with 42 CFR 438.202, the State maintains a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries.	MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. Iowa Medicaid performs an annual review of each MCO. This is generally conducted at the time of the annual External Quality Review (EQR) and includes a determination of contract compliance, including that for fraud and abuse reporting and training. EQR is performed as federally required, and committee reports are reviewed during an annual visit. The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the State and authenticated as it can be used during onsite visits and through regular reports.	Reviews are Conducted Annually	The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the state and authenticated as it can be used during onsite visits and through regular reports. The Medical Services Unit contractor conducts an annual EQR of each managed care entity to ensure that they are following the outlined QA/QI plan. In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to HHS.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas.	MCO QM/QI programs must have objectives that are measurable, realistic, and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program, and the State Medical Services conducts an annual EQR of each MCO to ensure that they are following the outlined QA/QI plan.	Reviews are Conducted Annually	The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the state an authenticated as it can be used during onsite visits and through regular reports.
MCOs must attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or URAC.	If not already accredited, the MCO must demonstrate it has initiated the accreditation process as of the MCO's contract effective date. The MCO must achieve accreditation at the earliest date allowed by NCQA or URAC. Accreditation must be maintained throughout the life of the MCO's contract at no additional cost to the State. When accreditation standards conflict with the standards set forth in the MCO's contract, the contract prevails unless the accreditation standard is more stringent.	Reviews are Conducted Every Three Years	NCQA and URAC publicly report summarized plan performance, as well as accreditation type, accreditation expiration date, date of next review and accreditation status for all NCQA accredited plans in a report card available on the NCQA website. This report card provides a summary of overall plan performance on several standards and measures through an accreditation start rating comprised of five categories (access and service, qualified providers, staying health, getting better, living with illness).

	MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed.		

STATE PLAN UNDER TITLE XIX 0F THE SOCIAL SECURITY ACT

State/Territory: IOWA

STANDARDS AND METHODS TO ASSURE HIGH QUALITY CARE

The following methods help assure quality of care and services under the Medical Assistance program.

1. A Medical Assistance Advisory Council assists the Department in planning the scope and content of medical services provided under the program.

2. The services of professional technical advisory committees are used for consultation on all services provided under the program.

3. Procedures exist to assure that workers in local Health and Human Services offices can assist people in securing necessary medical services.

4. Procedures are in effect to pay for necessary transportation of recipients to and from providers of medical and health services.

5. The State has in effect a contract with the Iowa State Department of Inspections and Appeals to survey intermediate care facilities, intermediate care facilities for persons with intellectual disabilities and skilled nursing facilities and to certify whether they meet the conditions to participate as providers of service under the Medical Assistance program.

6. The Department has in effect a Utilization Review Plan for evaluation and surveillance of the quality and quantity of all medical and health services provided under the program.

7. Physician certification, recertification and quality of care issues for the long-term care population are the responsibility of Iowa Medicaid's Medical Services Unit, which is the Professional Standards Review Organization in Iowa.