STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Calendar Year (CY) 2023 Readiness Review Report

for

Molina Healthcare of Iowa, Inc.

June 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

The State of Iowa, Department of Health and Human Services (HHS) administers and oversees the Iowa Medicaid managed care program, which provides Medicaid and Children's Health Insurance Program (CHIP, also referred to as Hawki) benefits to members. The Iowa Medicaid managed care program, in operation since 2016, covers acute, primary, specialty, pharmacy, and behavioral health services, as well as long-term services and supports (LTSS), for the majority of the Medicaid population (i.e., children, parents with children, individuals with disabilities, elderly individuals, pregnant women, and low-income adults).

On February 17, 2022, HHS released a request for proposal (RFP) to solicit responses from managed care organizations (MCOs) qualified to provide managed care services designed in support of the Title XIX (Medicaid) and Title XXI (CHIP) medical assistance programs. Through the RFP process, HHS selected two MCOs to administer the covered services under the Iowa Medicaid managed care program effective July 1, 2023. Although one of the selected entities (Amerigroup Iowa) is an existing MCO and one MCO (Iowa Total Care) is presently under contract with HHS, and both MCOs are currently providing services to Iowa Medicaid and Iowa Hawki managed care members, one MCO (Molina Healthcare of Iowa, Inc.) was newly selected for the Iowa Medicaid managed care program.

In accordance with 42 Code of Federal Regulations (CFR) §438.66(d)(1), a state must assess the readiness of each MCO with which it contracts when the specific MCO has not previously contracted with the State. As such, HHS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a readiness review of Molina Healthcare of Iowa, Inc., on behalf of HHS. Table 1-1 displays the naming conventions and address information for the newly contracted MCO.

Table 1-1—MCO Information

MCO Long Name	Molina Healthcare of Iowa, Inc.
MCO Short Name	Molina of Iowa
MCO Address	500 SW 7th Street Des Moines, IA 50309

Readiness Review Process

The readiness review for Molina of Iowa included an assessment of all key program areas noted in 42 CFR §438.66(d)(4), which are presented in Table 1-2. The key program areas were divided into three readiness review components—Operational,[1-1] Information Systems Management, and Financial Management—and each component was assessed using a variety of tools, staff interviews, information system demonstrations, testing scenarios, and/or requested data submissions. Please refer to Section 2 for a detailed methodology of the readiness review activity.

Table 1-2—Federal Readiness Review Areas

Federal Readiness Review Areas
Operations/Administration
Administrative Staffing and Resources
Delegation and Oversight
Member and Provider Communications
Grievance and Appeals
Member Services and Outreach
Provider Network Management
Program Integrity/Compliance
Service Delivery
Case Management/Care Coordination/Service Planning
Quality Improvement
Utilization Review
Financial Management
Financial Reporting and Monitoring
Financial Solvency
Systems Management
Claims Management
Encounter Data Management
Enrollment Information Management

[1-1] The Operational component of the readiness review includes Operations/Administration and Service Delivery.

Summary of Results

In accordance with 42 CFR §438.66(d)(3), the readiness review included a desk review of documents related to operational, information systems, and financial management areas, and a three-day on-site review and a subsequent one-day virtual review to interview Molina of Iowa staff members and leadership managing key operational areas and supporting functions. HSAG also observed system demonstrations of multiple information systems used by Molina of Iowa to support activities in applicable program areas and the outcomes associated with HSAG-developed claims testing scenarios.

Summary of Results for Operational Readiness Review

The Operational component of the readiness review included an assessment of Molina of Iowa's responses to the MCO Readiness Review Questionnaire, which provided HSAG with pertinent information about the MCO's organization, staffing and resources, systems, and contingency plans. The Operational component also included a review of federal and state-specific requirements separated into 14[1-2] program areas, called standards, as displayed in Table 1-3. These standards and the elements they contained were further supported by evidence obtained through the following:

- Seventeen checklist reviews (i.e., Marketing, Member Handbook, Member Rights, Member Services Helpline, New Member Communications, Provider Directory, Stakeholder Engagement and Education, Appointment Times, Time and Distance, Care Coordination, Community-Based Case Management, Home- and Community-Based Services, Clinical Records, Provider Contract, Provider Manual, Staff Training, and Staffing)
- Two file reviews (i.e., Credentialing and Delegated Entities)
- System demonstrations, such as the following:
  - Customer Service/Call Center
  - Enrollment
  - Care Management
  - Utilization Management (service authorizations)
  - Credentialing
  - Grievances and Appeals
  - Claims/Encounters (storage and processing)
  - Provider Network Management (fee schedule maintenance, provider directory)
  - Program Integrity (Health Insurance Portability and Accountability Act [HIPAA] violations and fraud/abuse tracking applications)

[1-2] While the Operational standards consist of 15 program areas, the Health Information Systems Standard was reviewed as a component of the Information Systems Readiness Review.

Table 1-3 presents the summary of results of the Operational readiness review assessment performed by HSAG for Molina of Iowa. The table lists the standards reviewed and the total number of elements (requirements) reviewed within each of the readiness review program areas (standards), the number of elements *Met* and *Not Met*, percentage of elements with a score of *Met*, and the overall *Met* and *Not Met* percentages.

Table 1-3—Summary of Results for Operational Readiness Review

Standard		Elements/Requirements Assessed			
		Number of Elements	Number *Met*	Number *Not Met*	Percent *Met*
I	Disenrollment: Requirements and Limitations	6	6	0	100%
II	Member Rights and Member Information	38	37	1	97%
III	Emergency and Poststabilization of Services	15	15	0	100%
IV	Availability of Services	18	16	2	89%
V	Assurances of Adequate Capacity and Services	9	8	1	89%
VI	Coordination and Continuity of Care	21	17	4	81%
VII	Coverage and Authorization of Services	45	43	2	96%
VIII	Provider Selection	29	28	1	97%
IX	Confidentiality	19	19	0	100%
X	Grievance and Appeal Systems	42	39	3	93%
XI	Subcontractual Relationships and Delegation	12	11	1	92%
XII	Practice Guidelines	6	6	0	100%
XIII	Health Information Systems	This program area was assessed through the Information Systems Readiness Review.			
XIV	Quality Assessment and Performance Improvement Program	40	38	2	95%
XV	Program Integrity	19	19	0	100%
	Total	**319**	**302**	**17**	**95%**
Overall Percent *Met* (No Action Required)			**95%**		
Overall Percent *Not Met* (Action Required)			**5%**		

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.
Number *Not Met* = The total number of elements within each standard that did not support readiness.

Molina of Iowa demonstrated readiness in 302 of 319 elements, with an overall completion status of *Met* in Disenrollment: Requirements and Limitations, Emergency and Poststabilization Services, Confidentiality, Practice Guidelines, and Program Integrity indicating the necessary policies, procedures, and initiatives are in place to effectively support Molina of Iowa's readiness in these program areas. However, 17 elements were determined as *Not Met*, indicating Molina of Iowa has

opportunities for improvement to operationalize the related requirements in accordance with federal and State regulations under the remaining 10 program areas.

Of note, several of the Iowa-specific requirements were included in Molina of Iowa's policies and procedures verbatim or were included in a policy addendum. However, this initially made it challenging for HSAG reviewers to assess how several of these requirements will be operationalized. During the site review, and through system demonstrations, the MCO staff members demonstrated an understanding of these requirements and how they will be implemented. As such, comprehensive and thorough staff training is needed to ensure staff members effectively operationalize the requirements outlined in policy. Additionally, several of the MCO's policies and procedures included typographical errors, the outdated Iowa Medicaid agency name, and references to other Molina programs that may not apply to the Iowa Medicaid managed care program. While this was brought to Molina of Iowa's attention to correct, HSAG recommends that the MCO conduct a thorough review of all Iowa-specific policies and procedures and update as appropriate.

While Molina of Iowa demonstrated readiness for most elements, some elements required HSAG to conduct a final review of the MCO's policies and procedures, member and provider materials, and the systems that will be used to support the Iowa Medicaid managed care program to Molina of Iowa's plan to manage the assigned membership. Additionally, Molina of Iowa will be expected to demonstrate implementation of its policies, procedures, and plans in future compliance activities.

Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Remediation Plan

Molina of Iowa was required to submit a remediation plan to remedy all Operational readiness review requirements determined to be *Not Met.* All *Not Met* items were required to be successfully remediated prior to the program effective date of July 1, 2023. Molina of Iowa's Operational remediation plan is located in Appendix B.

Table 1-4 presents the summary of results of the Operational readiness review assessment for Molina of Iowa upon completion of its remediation plan and supporting documents submitted as of May 31, 2023, and live systems demonstrations as of June 20, 2023. Table 1-4 lists the standards reviewed, the total number of elements (requirements) reviewed within each of the readiness review program areas (standards), and the number of *Met* and *Not Met* elements for each program area. An overall readiness status of *Ready* or *Not Ready* for each individual program area is also presented.

Table 1-4—Summary of Results for Operational Readiness Review as of June 20, 2023

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *Not Met*	Overall Readiness Status
I	Disenrollment: Requirements and Limitations	6	6	0	Ready

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *Not Met*	Overall Readiness Status
II	Member Rights and Member Information	38	38	0	Ready
III	Emergency and Poststabilization of Services	15	15	0	Ready
IV	Availability of Services	18	18	0	Ready
V	Assurances of Adequate Capacity and Services	9	9	0	Ready
VI	Coordination and Continuity of Care	21	21	0	Ready
VII	Coverage and Authorization of Services	45	45	0	Ready
VIII	Provider Selection	29	29	0	Ready
IX	Confidentiality	19	19	0	Ready
X	Grievance and Appeal Systems	42	42	0	Ready
XI	Subcontractual Relationships and Delegation	12	12	0	Ready
XII	Practice Guidelines	6	6	0	Ready
XIII	Health Information Systems	This program area was assessed through the Information Systems Readiness Review.			
XIV	Quality Assessment and Performance Improvement Program	40	40	0	Ready
XV	Program Integrity	19	19	0	Ready
Total		**319**	**319**	**0**	**NA**
Percent *Met* (No Action Required)				**100%**	
Percent *Not Met* (Action Required)				**0%**	

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.
Number *Not Met* = The total number of elements within each standard that did not support readiness.
NA = An Overall Readiness Status Total is not applicable to the readiness review as each program area was assessed independently.

HSAG reviewed Molina of Iowa's remediation plan and supporting documentation and determined that Molina of Iowa demonstrated sufficient operations and the capacity to provide services to members enrolled in the Iowa Medicaid managed care program.

Molina of Iowa's completed remediation plan and HSAG's acceptance of the remediation plan, including readiness status and recommendations for continued program enhancements, are documented in Appendix B.

Summary of Results for Information Systems Readiness Review

The Information Systems component of the readiness review assessed the MCO's ability to manage and adjudicate a set of test claims, and to subsequently prepare encounters based on the adjudicated test cases. The Information Systems component also included an assessment of Molina of Iowa's systems

and processes in place to process and manage enrollment data, and to support performance measure reporting for the Iowa Medicaid and Iowa Hawki populations. As part of these assessments, HSAG reviewed Molina of Iowa's responses within the completed Information Systems Capabilities Assessment Tool (ISCAT); documentation provided to support federal and state-specific requirements delineated within three Information Systems evaluation tools, called standards, as displayed in Table 1-5; and the outcomes observed through test claim scenarios (i.e., Professional, Institutional, Pharmacy, and LTSS claims).

Table 1-5 also presents the summary of results of the Information Systems readiness review assessment performed by HSAG for Molina of Iowa and lists the Information Systems standards reviewed, the total number of requirements reviewed within each of the systems-related program areas (standards), the percentage of *Met* and *Not Met* elements for each individual program area, and the overall *Met* and *Not Met* percentages.

Table 1-5—Summary of Results for Information Systems Readiness Review

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *Not Met*	Percent *Met*
I	Enrollment Systems	5	3	2	60%
II	Claims and Encounter Systems	4	3	1	75%
XIII	Health Information Systems	16	13	3	81%
Total		**25**	**19**	**6**	**76%**
Percent *Met* (No Action Required)				**76%**	
Percent *Not Met* (Action Required)				**24%**	

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.
Number *Not Met* = The total number of elements within each standard that did not support readiness.

Molina of Iowa demonstrated readiness in 19 of 25 standard elements, with an overall completion status of *Met* in 76 percent of the standards, indicating some systems and documentation are in place to effectively support Molina of Iowa's readiness in these related program areas. However, six elements were determined as *Not Met*, indicating Molina of Iowa had opportunities to improve its documentation and further demonstrate system readiness for enrollment, claims, encounters, and other health information system requirements. These findings were further supported through the test claim scenarios and the outcomes observed through the system demonstrations, which specifically indicated the following:

- Molina of Iowa was able to demonstrate readiness for processing claims in its test environment; however, the MCO must confirm readiness for processing all claim types in the production environment.

- Molina of Iowa had policies and procedures in place in alignment with the required elements for most standards; however, there were some areas that required further documentation and clarification.
- Detailed findings, including recommendations for system enhancements, are documented in Appendix C. Appendix D provides the test claim scenarios for professional, institutional, LTSS, and pharmacy services that were demonstrated by Molina of Iowa to support readiness in accepting and maintaining member enrollment data from HHS and to confirm system readiness to support accurate claims payment and complete encounter submissions.

Remediation Plan

Molina of Iowa was required to submit a remediation plan to remedy all Information Systems readiness review requirements determined to be *Not Met* prior to the program implementation effective date of July 1, 2023. Molina of Iowa's Information Systems remediation plan is located in Appendix E.

Table 1-6 presents the summary of results of the Information Systems readiness review assessment upon completion of Molina of Iowa's remediation plan and supporting documents submitted as of May 31, 2023, and live systems demonstrations as of June 20, 2023. Table 1-6 lists the Information Systems standards reviewed, the total number of requirements reviewed within each of the systems-related program areas (standards), and the overall readiness status for each individual program area.

Table 1-6—Summary of Results for Information Systems Readiness Review as of June 20, 2023

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *Not Met**	Overall Readiness Status
I	Enrollment Systems	5	5	0	Ready
II	Claims and Encounter Systems	4	4	0	Ready
XIII	Health Information Systems	16	16	0	Ready
Total		**25**	**25**	**0**	**NA**
Percent *Met* (No Action Required)				**100%**	
Percent *Not Met* (Action Required)				**0%**	

* Incomplete system-related elements must be remedied prior to enrolling recipients.
Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.
Number *Not Met* = The total number of elements within each standard that did not support readiness.
NA = An Overall Readiness Status Total is not applicable to the readiness review as each program area was assessed independently.

Molina of Iowa demonstrated readiness for information systems and data sources that contribute to Molina of Iowa's processing of claims/encounter and enrollment data specific to the Iowa Medicaid managed care program.

Molina of Iowa's completed remediation plan and HSAG's acceptance of the remediation plan, including readiness status and recommendations for continued program enhancements, are documented in Appendix E.

Summary of Results for Financial Management Readiness Review

The Financial Management component of the readiness review assessed Molina of Iowa's readiness against a variety of standards including those established by the National Association of Insurance Commissioners (NAIC) in addition to an evaluation of readiness to meet the financial management requirements established by HHS and within the applicable subparts of Title 42 CFR. Table 1-7 presents the summary of results of the Financial Management readiness review assessment performed by HSAG for Molina of Iowa. Table 1-7 displays the Financial Management standards reviewed and whether the standard demonstrated financial readiness to provide services under the Iowa Medicaid managed care program.

Table 1-7—Summary of Results for Financial Management Readiness Review

Standard	Number of Elements Reviewed	Number of Elements *Demonstrating Readiness*
Financial Reporting and Monitoring	5	5
Financial Solvency	7	7

Molina of Iowa demonstrated readiness in Financial Reporting and Financial Solvency, indicating the MCO has the ability to meet its financial obligations and manage operations required under the Iowa Medicaid managed care program and its contract with HHS.

Appendix F provides the data files requested by HSAG and subsequently provided by Molina of Iowa to support financial readiness.

Remediation Plan

Molina of Iowa was not required to submit a remediation plan regarding the Financial Management readiness review requirements.

2. Methodology

Readiness Review Process

The readiness review included an assessment of all key program areas noted in 42 CFR §438.66(d)(4), which are presented in Table 2-1. The key program areas and related requirements were delineated between three separate readiness review components—Operational,[2-1] Information Systems Management, and Financial Management—which were evaluated simultaneously. Table 2-2 provides a crosswalk that compares the federal readiness review requirements, State contract requirements, and federal standards applicable for compliance reviews under 42 CFR §438.358(b)(1)(iii) to the HSAG readiness review standards and tools.

Table 2-1—Federal Readiness Review Areas

Federal Readiness Review Areas
Operations/Administration
Administrative Staffing and Resources
Delegation and Oversight
Member and Provider Communications
Grievance and Appeals
Member Services and Outreach
Provider Network Management
Program Integrity/Compliance
Service Delivery
Case Management/Care Coordination/Service Planning
Quality Improvement
Utilization Review
Financial Management
Financial Reporting and Monitoring
Financial Solvency
Systems Management
Claims Management
Encounter Data Management
Enrollment Information Management

[2-1] The Operational component of the readiness review includes Operations/Administration and Service Delivery.

Table 2-2—Readiness Review Requirements and Standards Crosswalk

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/MCO Contract	HSAG Readiness Review Standards and Tools
Operations/Administration			
A. Administrative staffing and resources	• Not applicable	• Written policies and procedures • Organizational structures (key personnel requirements) • Implementation plan	• Standard XIV—Quality Assessment and Performance Improvement Program • Staffing Checklist (Standard XIV) • Staff Training Checklist (Standard XIV)
B. Delegation and oversight of MCO responsibilities	• 438.230 Subcontractual relationships and delegation	• Written policies and procedures • Subcontractor requirements	• Standard XI—Subcontractual Relationships and Delegation • Delegation File Review Tool (Standard XI)
C. Enrollee and provider communications	• 438.10 Information requirements • Subpart C—Enrollee Rights and Protections – 438.100 Enrollee rights – 438.102 Provider-enrollee communications – 438.104 Marketing activities – 438.106 Liability for payment – 438.114 Emergency and poststabilization services	• Written policies and procedures • Member rights, materials, and services • Marketing materials and activities • Member handbook	• Standard II—Member Rights and Member Information • Standard VII—Coverage and Authorization of Services • Standard VIII—Provider Selection • Provider Manual Checklist (Standard VIII) • Member Handbook Checklist (Standard II) • Marketing Checklist (Standard II) • New Member Communications Checklist (Standard II) • Provider Directory Checklist (Standard II) • Member Rights Checklist (Standard II) • Stakeholder Engagement and Education Checklist (Standard II)

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/MCO Contract	HSAG Readiness Review Standards and Tools
D. Grievance and appeals	• Subpart F—Grievance and Appeal System – 438.400 Definitions – 438.402 General requirements – 438.404 Timely and adequate notice of adverse benefit determination – 438.406 Handling of grievances and appeals – 438.408 Resolution and notification: Grievances and appeals – 438.410 Expedited resolution of appeals – 438.414 Information about the grievance and appeal system to providers and subcontractors – 438.416 Recordkeeping requirements – 438.420 Continuation of benefits while appeal and the State fair hearing are pending – 438.424 Effectuation of reversed appeal resolutions	• Written policies and procedures • Maintenance of records • Grievances, appeals, and State fair hearings	• Standard VII—Coverage and Authorization of Services • Standard X—Grievance and Appeal Systems
E. Member services and outreach	• 438.10 Information requirements • 438.56 Disenrollment: Requirements and limitations	• Written policies and procedures • Enrollment discrimination • Member disenrollment • Marketing	• Standard II—Member Rights and Member Information • Standard I—Disenrollment Requirements and Limitations • Member Handbook Checklist (Standard II)

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/MCO Contract	HSAG Readiness Review Standards and Tools
		• Member communications • Member services hotline • Electronic communications • Member website • Health education and initiatives • Cost and quality information • Advance directive information • Member rights • Redetermination assistance • Member stakeholder engagement • Stakeholder education • Implementation support	• Member Services Helpline Checklist (Standard II) • Marketing Checklist (Standard II) • New Member Communications Checklist (Standard II) • Provider Directory Checklist (Standard II)
F. Provider network management	• 438.12 Provider discrimination prohibited • 438.206 Availability of services • 438.207 Assurances of adequate capacity and services • 438.214 Provider selection	• Written policies and procedures • Covered benefits • Network development and adequacy • Requirements by provider type • Provider network reports and performance targets	• Standard IV—Availability of Services • Standard V—Assurances of Adequate Capacity and Services • Standard VIII—Provider Selection • Provider Contract Checklist (Standard VIII) • Provider Manual Checklist (Standard VIII) • Credentialing File Review Tool (Standard VIII) • Provider Directory Checklist (Standard II)

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/MCO Contract	HSAG Readiness Review Standards and Tools
G. Program integrity/compliance	• 438.224 Confidentiality • 438.608 Program integrity requirements • 438.610 Prohibited affiliations	• Written policies and procedures • Maintenance of records • Disclosures • Confidentiality of member medical records and other information, including HIPAA compliance • General requirements and authorities • Program integrity plan (compliance program) • Required fraud and abuse activities • Reporting fraud and abuse • Coordination and program integrity efforts • Verification of services provided • Obligation to suspend payments to providers • Required provider ownership and control disclosures • Contractor reporting obligations for adverse actions taken on provider • Applications for program integrity reasons • Enforcement of Iowa Medicaid program rules	• Standard IX—Confidentiality • Standard XV–Program Integrity

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/MCO Contract	HSAG Readiness Review Standards and Tools
Service Delivery			
A. Case management/care coordination/service planning	• 438.208 Coordination and continuity of care • 438.224 Confidentiality	• Written policies and procedures • Maintenance of records • Continuity of care • Care management structure • Level of care and support assessment • Community-based case management	• Standard VI—Coordination and Continuity of Care • Standard XII—Practice Guidelines • Care Coordination Checklist (Standard VI) • Community-Based Case Management Checklist (Standard VI) • Clinical Records Checklist (Standard VI) • Home and Community Based Services Checklist (Standard VI)
B. Quality improvement	• 438.330 Quality assessment and performance improvement program	• Written policies and procedures • Contractor quality management/quality improvement (QM/QI) program • Critical incidents • Population health • Provider preventable conditions • Quality management reports and performance targets	• Standard XIV—Quality Assessment and Performance Improvement Program
C. Utilization review	• 438.114 Emergency and poststabilization services • 438.210 Coverage and authorization of services • 438.236 Practice guidelines	• Written policies and procedures • Maintenance of records • Utilization management program • Prior authorization • Utilization reports and performance targets	• Standard VII—Coverage and Authorization of Services • Standard XII—Practice Guidelines

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/MCO Contract	HSAG Readiness Review Standards and Tools
Financial Management			
A. Financial reporting and monitoring	• 438.116 Solvency Standards	• Financial reports and performance targets	• IA Financial Management Readiness Review Tool
B. Financial solvency			
Systems Management			
A. Claims management	• 438.242 Health information systems	• Information system services • Contingency and continuity planning • Data exchange • Claims processing • Encounter claims submission • Third party liability processing • Health information technology • Claims reports and performance targets	• Standard XIII—Health Information Systems • Information Systems Standards I and II—Enrollment Systems and Claims and Encounter Systems • ISCAT • Claims scenarios testing
B. Encounter data and enrollment information management			

Table 2-3 provides the timeline and key dates for Molina of Iowa's readiness review, which included a desk review and an on-site visit.

Table 2-3—Key Readiness Review Dates

Key Readiness Review Dates	
Task Description	**Date**
HSAG provides Readiness Review information packet to MCO ([Operational, Information Systems, and Financial Management]; enrollment/claims testing scenarios; and documents).	1/9/2023
HSAG hosts webinar with MCO.	1/11/2023
MCO uploads completed tools, questionnaire, supporting documents (including provider network adequacy status), and universe files for credentialing and delegation file reviews to HSAG's Secure Access File Exchange (SAFE).	2/21/2023
HSAG submits sample selections for case file reviews to SAFE for MCO retrieval.	2/23/2023
MCO uploads supporting documentation for the credentialing and delegation file reviews to SAFE.	3/8/2023

Key Readiness Review Dates	
Task Description	**Date**
HSAG conducts on-site review.	4/4/2023–4/6/2023
HSAG conducts virtual review.	4/10/2023
MCO conducts ongoing remediation of noted deficiencies and submits periodic updated provider network adequacy status/supporting evidence to HSAG/HHS.	4/7/23—Implementation

Methods for Data Collection

To support the readiness review process, HSAG developed multiple data collection tools to document findings from the desk review and on-site visit. To obtain comprehensive information about Molina of Iowa, HSAG developed the MCO Readiness Review Questionnaire that Molina of Iowa completed with information about its overall organization structure and processes, including:

- Full name and physical address of the Iowa MCO.
- Key contact information.
- Primary staff members accountable for each program area under review.
- Evidence that the MCO is licensed and in good standing in the State of Iowa as a health maintenance organization (HMO) in accordance with Iowa Administrative Code (IAC) Chapter 191-40 and Contract A.02.
- The MCO's implementation plan for the Iowa Medicaid managed care program.
- Provider network onboarding plan.
- High-level organizational chart depicting the names, credentials, and positions of the key staff responsible for the contract with HHS.
- Description of Molina of Iowa's training program and the process for training staff members responsible for managing Iowa Medicaid and Iowa Hawki populations.

The MCO Readiness Review Questionnaire also required Molina of Iowa to provide the following information for each program area under review:

- Organizational chart and key staff members, including the number of full-time equivalents assigned to the Iowa Medicaid managed care program.
- Delineation of responsibilities between corporate staff and state-level staff.
- Process for assessing the need for additional staffing and resources to accommodate the Iowa Medicaid and Iowa Hawki populations.
- Recruitment strategies for additional staffing and resources, including the name and number of new positions and how many of those positions had been filled versus those that were still vacant.

- Process for evaluating the sufficiency of staffing and resources after program implementation on July 1, 2023.
- The MCO's contingency plan for unfilled positions.
- System(s) used to maintain data (e.g., enrollment and disenrollment information, grievances, appeals, service authorization denials).
- High-level overview of the program area's processes.
- List of subcontractors/delegated entities responsible for managed care contract requirements, and the functions or activities being delegated.

The completed MCO Readiness Review Questionnaire is located in Appendix H.

HSAG also developed a set of data collection tools that included all Medicaid managed care standards required under 42 CFR §438.358 (b)(1)(iii) and the requirements related to operations/administration, service delivery, information systems, and financial management areas delineated under 42 CFR §438.66 (d)(4). These tools included 17 standard tools (14 Operational and three Information Systems), 17 checklist reviews, two case file review tools that supported readiness with the elements under review in the Operational standards, an ISCAT and test claims scenarios worksheet to document system readiness, and a Microsoft (MS) Excel workbook to capture readiness for the Financial Management standards. Each completed standard tool, the ISCAT, and the MS Excel workbook used to document financial management readiness are located in appendices A, C, and F.

On November 4, 2022, HSAG initiated the readiness review activities by providing Molina of Iowa with an email and the MCO Readiness Review Questionnaire to complete, which provided HSAG with pertinent information about the MCO's organization, staffing and resources, systems, and contingency plans.

A Submission Requirements Checklist was also provided to Molina of Iowa that described the readiness review activities and timeline; logistical requirements; data submission requirements; and an overview of each tool used to document readiness review findings, including the expectations for Molina of Iowa to provide supporting evidence to confirm readiness in each program area under review. A technical assistance webinar with Molina of Iowa was conducted to walk through the readiness review expectations and data collections tools, and to provide the MCO the opportunity to ask questions.

Description of Data Obtained

To assess Molina of Iowa's ability and capacity to perform managed care activities consistent with federal regulations, HSAG obtained information from a wide range of written documents completed or produced by Molina of Iowa, including, but not limited to, the following:

- Organizational questionnaire
- Staffing structure and staffing/hiring plan
- Training plan and training agendas

- ISCAT
- Program area-specific policies, procedures, processes, descriptions, and workflows
- Provider materials, including the provider manual and contract templates
- Member materials, including the member handbook, notice templates, and provider directory
- Sample reports across a broad range of performance and content areas
- Network adequacy data and information, including contracting/credentialing status
- Financial reports and attestations

HSAG obtained additional information for the readiness review through interactive discussions and interviews with Molina of Iowa key staff members and system demonstrations of key program areas such as the following:

- Customer service/call center
- Enrollment
- Care management
- Utilization management (service authorizations)
- Credentialing
- Grievances and appeals
- Claims/encounters (storage and processing)
- Provider network management (fee schedule maintenance, provider directory)
- Program integrity (HIPAA violations and fraud/abuse tracking applications)
- Member/provider portals

The findings from the desk review and the on-site review were documented within the data collection tools.

Readiness Review Activities

To complete the readiness review, HSAG conducted pre-review, on-site review, and post-review activities.

Pre-review activities included:

- Developing the questionnaire, data requests, and readiness review data collection tools.
- Preparing and forwarding to the MCO an introduction and submission requirements document with instructions for submitting requested documentation to HSAG for its desk review.
- Scheduling the on-site review.
- Conducting a readiness review preparation webinar.

- Conducting a desk review of documents. HSAG conducted a desk review of the information obtained from the MCO. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the MCO's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Developing an agenda for the three-day on-site review and subsequent one-day virtual review.

On-site review activities included:

- Facilitating an opening conference, with introductions and a review of the agenda and logistics for HSAG's on-site review activities.
- Interviewing MCO key administrative and program staff members.
- Reviewing the MCO's data systems used in its operations.
- Reviewing the MCO's test claims scenarios to observe the outcomes.
- Facilitating a closing conference during which HSAG reviewers summarized their preliminary findings.

Post-review activities: HSAG reviewers aggregated findings to produce this readiness review report. In addition, HSAG created remediation plan templates for the MCO to detail its plans to remedy the deficiencies noted. The readiness review data collection tools contained the findings and recommendations for each requirement found to be *Not Met* during the readiness review. The MCO was required to use the HSAG-developed remediation plan templates to submit its plans to HSAG and HHS to remediate all requirements scored *Not Met* or *Not Ready* (Financial Management). The criteria used in evaluating the sufficiency of the remediation plan were:

- The completeness of the remediation plan in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization has taken or will take.
- The degree to which the planned activities/interventions met the intent of the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Molina of Iowa was required to resubmit any remediation plans that did not meet the above criteria until approved by HHS. Although HSAG evaluated the MCO's remediation plans and provided recommendations to HHS, HHS maintained ultimate authority for approving remediation plans submitted in response to the readiness review.

Data Aggregation and Analysis

From a review of documents, observations, and interviews with key staff during the readiness review, HSAG reviewers assigned a score for each requirement within a program area as *Met* or *Not Met* (Operational and Information Systems components only).

HSAG's scoring included the following:

- ***Met*** indicates full compliance defined as *all* of the following:
  - All documentation was present.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) contained sufficient information to ascertain how the MCO met this requirement.
  - The documentation included appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
  - Staff members provided responses consistent with the policies and/or processes described in documentation.
- ***Not Met*** indicates noncompliance defined as *one or more* of the following:
  - A portion of the documentation was unclear or contained conflicting information that did not address the regulatory requirements.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) did not contain the information needed to ascertain how the MCO met this requirement.
  - The documentation did not have the appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
  - Staff members had little or no knowledge of processes or issues addressed by the regulatory and/or contractual provisions.
  - For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall finding of *Not Met*, regardless of the findings noted for the remaining components.

Subsequently, each program area was assigned an overall readiness status of *Ready* or *Not Ready*. All requirements within each program area must have been determined to be *Met* in order for the overall readiness for the program area to be assigned a status of *Ready*.

The overall readiness review findings for each program area and systems reviewed were subsequently documented within this Iowa CY 2023 MCO Readiness Review Report for submission to the Centers for Medicare & Medicaid Services (CMS) to support the State's obligations under 42 CFR §438.66(d)(2)(iii) and 42 CFR §438.3(a).

Appendix A. Operational Readiness Review Standards

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Enrollment Discrimination		
1. The MCO accepts new enrollment from individuals in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the Contract. a. The MCO does not discriminate against individuals eligible to enroll on the basis of health status or need for health care services. b. The MCO does not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. c. The MCO does not use any policy or practice that has the effect of discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. 42 CFR §438.3(d) Contract B.1.01–B.1.04	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • Policies and Procedures o IA_Enrollment and Disenrollment PnP Page 3 o IA_Included and Excluded Populations Page 3	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa, Inc. (“Molina Healthcare of Iowa”) does not discriminate and enrolls members based on the membership received on daily and monthly files. Members are enrolled in good faith based upon Data provided by the State. Staff Training will require all appropriate staff to be trained on the policy and procedure with documentation.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Disenrollment Requested by the MCO		
2. The MCO does not request disenrollment because of: a. An adverse change in the member's health status. b. The member's utilization of medical services. c. The member's diminished mental capacity. d. Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members). 42 CFR §438.56(b)(1-2) Contract B.5.01-B.5.02	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • Policies and Procedures o IA_Enrollment and Disenrollment PnP Page 2 and Page 6	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa enrollment does not request disenrollment from members. Members are disenrolled based on the data received on the daily and monthly 834. Enrollment will term if termination is received on the 834. Staff Training will require all appropriate staff to be trained on the policy and procedure with documentation.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
3. In requesting disenrollment, the MCO provides evidence to HHS that the MCO has not violated the prohibitions set forth in 42 CFR §438.56(b)(2). *At a minimum:* a. *The MCO's request must document that reasonable steps were taken to educate the member regarding proper behavior and the member refused to comply.* b. *The MCO has methods by which HHS is assured that disenrollment was not requested for any other reason.* c. *HHS retains sole authority for determining if this condition has been met and whether disenrollment will be approved.* 42 CFR §438.56(b)(1) 42 CFR §438.56(b)(3) Contract B.5.03–5.04	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • Policy and Procedure o IA_Enrollment and Disenrollment PnP Page 5	☒ Met ☐ Not Met

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa enrollment does not request disenrollment of members. Members are disenrolled based on the data received on the daily and monthly 834. Enrollment will term if termination is received on the 834. Staff Training will require all appropriate staff to be trained on the policy and procedure with documentation.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** While MCO staff members were aware of the expectation to notify HHS and provide supporting documentation should the MCO request disenrollment of a member, MCO staff members also explained that they are continuing to finalize reporting processes and that should HHS require a specific mode of notification to HHS, it will update its procedure accordingly. As such, HSAG recommends that the MCO update its enrollment and disenrollment policy per HHS' direction.		
Required Actions: None.		
Disenrollment Requested by the Member		
4. The member may request disenrollment from the MCO as follows: a. For cause, at any time. b. Without cause, at the following times: i. During the ninety (90) days following the date of the member's initial enrollment into the MCO, or during the ninety (90) days following the date HHS sends the member notice of that enrollment, whichever is later. ii. At least once every twelve (12) months thereafter. iii. Upon automatic enrollment under 42 CFR §438.56(g), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. iv. When HHS imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or HHS notifies the MCO of a determination of a violation of	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Staff training materials **Evidence as Submitted by the MCO:** • Policy and Procedure o IA_Enrollment and Disenrollment PnP Page 5-6 • Member Materials o IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 Pages and 82-83, 85-86	☒ Met ☐ Not Met

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
any requirement under sections 1903(m) or 1932 of the Act. 42 CFR §438.56(c) 42 CFR§438.56(g) 42 CFR §438.702(a)(4) Contract B.5.05–B.5.06		
MCO Description of Process: Molina Healthcare of Iowa enrollment follows State contract regarding member disenrollment request. Members are only terminated/disenrolled based on the data received on the daily and monthly 834. Staff Training will require all appropriate staff to be trained on the policy and procedure with documentation.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** While the member handbook included the requirements of sub-element (b)(iv), HSAG recommends that the MCO add this provision to its enrollment and disenrollment policy.		
Required Actions: None.		
Procedures for Disenrollment		
5. The following are causes for disenrollment: a. The member moves out of the MCO's service area. b. The plan does not, because of moral or religious objections, cover the service the member seeks. c. The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider (PCP) or another provider determines that receiving the services separately would subject the member to unnecessary risk. d. For members that use Managed Long-Term Services and Supports (MLTSS), the member would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO and, as a result,	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Staff training materials **Evidence as Submitted by the MCO:** • Policy and Procedure o IA_Enrollment and Disenrollment PnP Pages 5-6 • Member Material o IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 Pages 82-83 and 85-86	☒ Met ☐ Not Met

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
would experience a disruption in their residence or employment. e. For other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs. 42 CFR §438.56(d)(2) Contract B.5.07–B.5.10		
MCO Description of Process: There are causes for member disenrollments, member moving out of the service area, member is not satisfied with Molina Healthcare of Iowa and what is offered to name a few, for these reasons members have the right to request disenrollment from Molina Healthcare of Iowa. Staff Training will require all appropriate staff to be trained on the policy and procedure with documentation.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** HHS has indicated it will be updating the definition for "habilitation services" as follows: "Habilitation services means the 1915(i) State Plan Home and Community Based Services. Habilitation services are provided to maintain persons with functional deficits typically associated with chronic mental illness in their own homes and communities." As such, HSAG recommends that the MCO update this definition accordingly once it receives the contract revision.		
Required Actions: None.		
6. The member (or his or her representative) must request disenrollment by submitting an oral or written request *to the MCO*. a. The member must seek redress through the MCO's grievance process before the MCO can refer the member to HHS to request disenrollment. b. *If the member remains dissatisfied with the result of the grievance process, the MCO directs the member to contact HHS and request disenrollment from the MCO.* c. *HHS will make the final disenrollment determination.*	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Workflow delineating HHS and MCO responsibilities • Grievance resolution notice for disenrollment template • Staff training materials **Evidence as Submitted by the MCO:** • Policy and Procedure o IA_Enrollment and Disenrollment PnP Page 5 • Member Materials o IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 Pages 70, 83	☒ Met ☐ Not Met

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Note: If HHS fails to make a disenrollment determination within the specified time frames (i.e., the first day of the second month following the month in which the member requests disenrollment or the MCO refers the request to HHS), the disenrollment is considered approved for the effective date that would have been established had HHS made a determination in the specified time frame. 42 CFR §438.56(d)(1) 42 CFR §438.56(d)(5) Contract B.6.01–6.04	• Workflow o IA_Medicaid Grievance Policy Page 1-2 o IA_Standard Grievance SOP Page 1-2, 5-7 o IA_Disenrollment Grievance Workflow • Grievance Resolution Template o IA_Grv Disenrollment Letter	
MCO Description of Process: Members have the right to submit grievances for dissatisfaction of Molina Healthcare of Iowa, this can come in two main forms, oral and written. Staff Training will require all appropriate staff to be trained on the policy and procedure with documentation.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** MCO staff members explained that the grievance disenrollment letter template will be used when good cause for disenrollment has been met and the standard grievance resolution letter template will be used when good cause for disenrollment has not been met. As the standard grievance resolution letter template does not inform members to contact HHS should they wish to continue with the disenrollment request, MCO staff members will need to manually enter this information. To ensure this information is not inadvertently excluded due to manual error, HSAG recommends that the MCO develop a separate grievance disenrollment letter for when good cause is not met that includes template language informing the member to contact HHS to request disenrollment should the member remain dissatisfied with the results of the grievance resolution.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations						
Met	=	6	X	1	=	6
Not Met	=	0	X	0	=	0
Total	=	6	**Total Score**		=	6
				Total Score ÷ Total	=	100%

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCO has written policies regarding member rights. 42 CFR §438.100(a)(1) Contract F.16.01–F.16.02 Contract F16.04–F.16.07	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** • IA_ME.03-Member Rights and Responsibilities. Entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") has a Member Rights and Responsibility policy.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
2. The MCO complies with any applicable Federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2) Contract J.2.02	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual, provider contract, and provider training materials • Staff training materials • Auditing/oversight mechanisms **Evidence as Submitted by the MCO:** • IA_Provider Manual 020923 pg. 12 and pg. 22 Member Rights and Responsibilities • IA_Provider Orientation Slide 14 • IA_ME.03-Member Rights and Responsibilities. I. Purpose, page 1 • IA_Molina Iowa PSA (FFS) pg. 5, Section 2.2 • IA_HIPAA 101 HIPAA Privacy Training	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with all applicable laws that pertain to member rights as stated in our Member Rights and Responsibilities Policy. We have provided Evidence located in our Provider Manual pages 12 and 22, language in our Provider Contract Templates, and included in our Provider Orientations. Monitoring and oversight will be done through our member grievances department by reviewing member grievances		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
which are outlined within our Member Handbook. In addition, Provider Services also actively reminds providers on member rights in our annual reminder in the Provider Bulletin. Staff training materials, beyond HIPAA, are still under development but will also include Member Rights and Responsibilities.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Specific Rights		
3. The MCO complies with the requirements listed in the Member Rights Checklist. 42 CFR §438.100(b)(1) Contract C.2.12 Contract F.16.01–F.16.08	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Proof of reading grade level for member materials (e.g., member handbook, member welcome letter, etc.) • Staff training materials • HSAG will also use the results of the Member Rights Checklist **Evidence as Submitted by the MCO:** • IA_ME.03-Member Rights and Responsibilities. Pg. 1-2. II. Policy, Subsections a-j and Subsection m • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 65 and 66 Your Rights • IA_MemberHandbook Readability. Entire document • IA_HIPAA Privacy & Security - New Hire Training 2021	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has written policies regarding member rights and ensures members are made aware of their rights in member materials such as the member handbook. Staff training materials, beyond HIPAA, are still under development but will also include Member Rights and Responsibilities and other member materials, including handbook.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Information Requirements		
4. The MCO provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members. "Readily accessible" means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. 42 CFR §438.10(c)(1) Contract C.1.01	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook, provider directory, member welcome notice, etc. • Mechanism to assess reading level of member materials and supporting evidence (e.g., screenshots of reading level of member materials) • Proof of website accessibility • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 1. II Policy. A. Subsection a • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 65 Your Rights bullet 2 • IA_MemberHandbook Readability. Entire document. • IA_Member Website Accessibility. Entire document. • IA_Welcome and ID Card Backer. Entire document. • IA_Print Provider Directory Screenshot. (*from Molina SC)* Entire document.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa ensures all member materials are in a format easily understood and accessible by members and potential members. Staff training is under development and will include the Member Communication Policy and the Member Handbook.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
5. The MCO uses the definitions for managed care terminology developed by HHS including: a. Appeal, copayment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. 42 CFR §438.10(c)(4)(i) Contract C.8.07 Contract C.8.08 Contract Exhibit B	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Staff training materials **Evidence as Submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 85-91 Glossary of Terms. • IA_ME.01-Member Communication Policy pg. 4 Section I • IA_ME.04.01 Member Handbook Procedure pg. 4 Section 9 • IA MCO Terminology Training	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will train staff on relevant terminology and ensure accurate definitions are included in all member materials to facilitate member understanding and comprehension. Our Member Communication Policy and Member handbook Procedure outlines terminology that must be included in member materials such as the Member Handbook. Staff training is under development and will include, in addition to Terminology Training, the Member Handbook, the Member Communications Policy, and the Member Handbook Procedure.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
6. The MCO uses HHS-developed model member handbooks and member notices. 42 CFR §438.10(c)(4)(ii) Contract C.2.01 Contract C.8.11	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, grievance, and appeal letter templates, etc.	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 4. II Policy. Section I. • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023. Entire document. • IA_Member Appeal Letter. Entire document. • IA_Member Grievance Letter. Entire document. • IA_Medicaid Denial_Draft Iowa Health Link. Entire document.	
MCO Description of Process: Molina Healthcare of Iowa has used Iowa HHS models and templates for the member handbook and member notices when creating materials. The staff training is in development and will include the Member Handbook and Member Communication Policy.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Language and Format		
7. The MCO makes its written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the member or potential member at no cost. b. Include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size *(i.e., large print)* explaining the availability of written translation or oral interpretation to understand the information provided. c. Information on how to request auxiliary aids and services.	**HSAG Required Evidence:** • Policies and procedures • Provider directory in prevalent languages • Member handbook in prevalent languages • Definition of conspicuously visible font • Mechanisms to ensure taglines are included as part of all critical member materials • All template notices required to include taglines • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 1-2. II Policy. A. Subsections a. b. c. d. e. f. g. Pg. 5 Definitions	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
d. The toll-free and TTY/TDY telephone number of the MCO's member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost. "Prevalent languages" means English and Spanish, and any language spoken by at least five (5) percent of the general population in the MCO's service area. 42 CFR §438.10(d)(3) Contract C.1.19-C.1.22 Contract C.1.27(d)	• IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023. Entire document. • IA_Member Appeal Letter. Entire document. • IA_Member Grievance Letter. Entire document. • IA_Medicaid Denial_Draft. Iowa Health Link Entire document. • IA_PCP Termination Template. Entire document. • IA_Print Provider Directory Screenshot. (*from Molina SC)* Entire document.	
MCO Description of Process: Molina Healthcare of Iowa has a Member Communications policy in place that outlines the process for ensuring critical member materials are available in alternative formats, include taglines, and language services assistance. Staff training is in development but will include the Member Communications Policy.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations**: After the site review, the MCO provided an updated taglines document and indicated that this document would be used as an attachment to the member letters that met the conspicuously visible font size requirement. However, HSAG recommends that the MCO update the taglines to include the member services phone number within the tagline instead of referring the member to a phone number listed outside the tagline. Additionally, the MCO must ensure the updated taglines document is attached to all critical member materials to comply with federal rule.		
Required Actions: None.		
8. The MCO makes interpretation services available to each member free of charge. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. a. Oral interpretation requirements apply to all non-English languages, not just those that HHS identifies as prevalent. 42 CFR §438.10(d)(4) Contract C.1.23	**HSAG Required Evidence:** • Policies and procedures • Executed interpretation services (oral and written) contract(s) • Workflow for obtaining oral interpretation services • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 2. II Policy. A. Subsection g. and pg. 3 Section G.	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• IA_MPCC Policy MHI-MPCC-2 - Interpreter Services and Special Needs. Pg. 1. II Policy bullet 2. • IA Globo Amendment_14._2022-2027 SOW Renewal. Entire document. • IA Molina- Translation.com Addendum 3. Entire document. • IA ODS SOW 2 (Ad hoc jobs) 3.15.2021 Entire document. • IA Translations MSA Addendum. Entire document. • IA Translationscom-PO 410305 - _Sitecore_Addendum. Entire document. • IA_Oral Interpretation Workflow. Entire document.	
MCO Description of Process: Molina Healthcare of Iowa will make interpretation services free of charge all non-English languages. Staff training is in development but will include the Member Communications Policy and Interpretation Services and Workflow Process.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
9. The MCO notifies members: a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and c. How to access these services. 42 CFR §438.10(d)(5) Contract C.1.24	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 1-2 II Policy. A. Subsection d, e, g. and pg. 3. II. Policy. Section G. • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 3 Section: Welcome, pg. 7 Section: Accessibility, and pg. v. Language Assistance • IA_MPCC Policy MHI-MPCC-2 - Interpreter Services and Special Needs. Pg. 1. II Policy bullets 2 and 5.	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa will provide oral interpretation and written translation in prevalent languages at no to cost to members. Staff training is in development but will include the Member Communications Policy and explanation of how Members access language assistance.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
10. The MCO provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. Use a font size no smaller than twelve (12) point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency (LEP). "LEP" means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English. These members may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. 42 CFR §438.10(d)(6) Contract C.1.25 Contract C.1.27(a)-(c)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and member welcome notice • Mechanism to assess reading level of member materials and supporting evidence (e.g., screenshots of reading level of member materials) • Microsoft Word templates of member notices, such as an ABD notice, grievance resolution letter, appeal resolution letter, etc. • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 1-2. II Policy. A. Subsections a. b. c. d. e. g. • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 3 Section: Welcome, pg. 7 Section: Accessibility, and pg. Section: v. Language Assistance • IA_Member Appeal Letter Entire document • IA_Member Grievance Letter. Entire document • IA_Medicaid Denial_Draft Iowa Health Link. Entire document • IA_Quick Start Guide. • IA_Welcome ID Card and Backer • IA_WelcomeKit_ReadingScore. Entire document	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• IA_Member Grievance Reading Level. Entire document • IA_Member Appeal_Reading Level. Entire document • IA_Medicaid Denial_Reading Level. Entire document • IA_MemberHandbook Readability. Entire document	
MCO Description of Process: Molina Healthcare of Iowa will ensure that all member materials are written in an easily understood language and format, with those members with disabilities or Limited English Proficiency (LEP) taken into consideration. Staff training for this element is under development and will include the Member Communications Policy and the Member Handbook and assisting members with LEP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
11. *HHS provides the MCO with the primary language of each member. The MCO uses this information to ensure communication materials are distributed in the appropriate language.* Contract C.1.26	**HSAG Required Evidence:** • Policies and procedures • Mechanism for tracking members' primary language (e.g., screenshot of system) • Workflow for translating written member materials in a member's primary language • Workflow for providing member materials in primary language • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 3. Policy. Section H • IA_Primary Language. Entire document. • IA_Workflow for Providing Member Materials in Primary Language. Entire document. • IA_Workflow for Translating Written Member Materials. Entire document.	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa will use the data from Iowa HHS to ensure member materials are distributed to each member in their primary language. Member materials will be translated appropriately using our vendor ODS. Staff training is in development but will include the Member Communications Policy.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Information for Members		
12. The MCO makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. a. Notice to the member is provided by the later of thirty (30) calendar days prior to the effective date of the termination; or b. Fifteen (15) calendar days after receipt or issuance of the termination notice. 42 CFR §438.10(f)(1) 42 CFR §438.10(c)(5) Contract C.6.01	**HSAG Required Evidence:** • Policies and procedures • Workflow of provider termination process • Template of written notice to members of provider termination • Staff training materials **Evidence as Submitted by the MCO:** • IA PS-53_Provider Termination Process_all LOB Policy_signed (002) Entire Document. • IA PS-53_Provider Termination Process_all LOB Procedure_signed (002) Pg. 4. Section E. • IA PCP Change template for Members. Entire document. • IA PCP Termination template. Entire document. • IA_SOP Suspension Termination other Actions Pg.1 Pg. 2 Section F • IA_Member Moves Related to PCP Termination _MHI-EA-227 Pg. 1 Pg. 2 Section 4	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has provided our provider termination policy and procedure outlining the process with areas of responsibility as well as provided the PCP change and PCP termination template along with our SOP (Standard Operating Procedure). These documents will be used for staff training purposes. Member Moves Related to PCP Termination EA-227 outlines Molina Health Care of Iowa's procedure for written notification to Members when a PCP is changed or terminated.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
13. The MCO makes available upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i). 42 CFR §438.10(f)(3) 42 CFR §438.3(i) Contract C.6.02	**HSAG Required Evidence:** • Policies and procedures • List of physician incentive plans • Staff training materials **Evidence as Submitted by the MCO:** • IA 2023 Enterprise P4Q IA BP Strategy Overview Presentation FINAL 10.11.2022 PDF • IA BP Strategy Overview Presentation FINAL 10.11.2022 PDF • IA_MHI-VBP-001 Pay for Performance • IA_VB2-002_Pay for Performance SOP	☒ Met ☐ Not Met
MCO Description of Process: Molina makes physician incentive plans available upon request. Molina is currently in the process of establishing a performance-based incentive system for our Providers and will obtain the Agency approval prior to implementing any Provider incentives and before making any changes to an approved incentive. We have provided our IA 2023 Enterprise P4Q Enterprise P4Q program as evidence. We have also provided a Value Based Strategy Overview presentation specifically for Staff Training.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Member Handbook		
14. The MCO provides each member *and their authorized representative* with a member handbook upon enrollment, which must include all requirements listed in the Member Handbook Checklist.	**HSAG Required Evidence:** • Policies and procedures • Member handbook • Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website, etc.)	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
a. The member handbook is provided to the member within a reasonable time frame, *but no later than seven (7) days from notification of enrollment* 42 CFR §438.10(g)(1-3) 42 CFR §438.10(c)(5) Contract C.2.01–C.2.18	• Tracking mechanism for mailings of the member handbook or welcome notice • Staff training materials • HSAG will also use the results of the Member Handbook Checklist **Evidence as Submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023. Entire document • IA_ME.04.01 Member Handbook Procedure pg. 1 Paragraph 1, pg. 2 Paragraph 4, and pg. 2 Paragraph 7 • IA_ME.04 Member Handbook Policy Pg. 1. Section A • IA ODS SOW Member Materials Track Mechanisms	
MCO Description of Process: See Member Handbook Checklist. Molina Healthcare of Iowa will provide all members and their authorized representatives with a member handbook as outlined in Molina's Member Handbook Policy and Procedure. Staff training is under development and will include the Member Handbook and the Member Handbook Procedure.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
15. The member handbook will be considered provided if the MCO: a. Mails a printed copy of the information to the member's mailing address; b. Provides the information by email after obtaining the member's agreement to receive the information by email; c. Posts the information on the MCO's website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or	**HSAG Required Evidence:** • Policies and procedures • Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website, etc.) • Tracking mechanism for mailings of the member handbook or welcome notice **Evidence as Submitted by the MCO:** • IA_ME.04.01 Member Handbook Procedure pg. 1 Section 1 • IA_ME.04 Member Handbook Policy pg. 1 Section A	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. 42 CFR §438.10(g)(3) Contract C.3.01	• IA ODS SOW Member Materials Track Mechanisms. Entire document.	
MCO Description of Process: Molina Healthcare of Iowa outlines the mechanism for disseminating the member handbook within the Member Handbook procedure. Staff training is under development and will include the Member Handbook and the Member Handbook Procedure.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
16. The MCO gives each member notice of any change to the member handbook that HHS defines as significant in the information specified in the member handbook, at least thirty (30) days before the intended effective date of the change. *Significant changes include any change that may impact member accessibility to services and benefits in:* a. *Restrictions on the member's freedom of choice among network providers;* b. *Member rights and protections;* c. *Grievance and fair hearing procedures;* d. *Amount, duration, and scope of benefits available;* e. *Procedures for obtaining benefits, including authorization requirements;* f. *The extent to which, and how, members may obtain benefits from out-of-network providers;* g. *The extent to which, and how, after-hours and emergency coverage are provided;* h. *Policy on referrals for specialty care and for other benefits not furnished by the member's primary care provider; or* i. *Cost sharing.*	**HSAG Required Evidence:** • Policies and procedures • Workflow • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.04.01 Member Handbook Procedure pg. 4-5 Section 10 Subsections a and c • IA_ME.04 Member Handbook Policy pg. 1 Section C • IA_Significant Change to MH Workflow. Entire document. • Staff training is under development and will include the Member Handbook Policy and the Member Handbook Procedure.	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.10(g)(4) Contract C.2.19–C.2.20		
MCO Description of Process: Molina Healthcare of Iowa has a process for notifying members of a significant change to the information in the Member Handbook as outlined in the Member Handbook Policy and Procedure.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Provider Directory		
17. The MCO makes the provider directory available in paper form upon request and electronic form. a. The provider directory includes the information from the Provider Directory Checklist. 42 CFR §438.10(h)(1-2) 42 CFR §438.10(c)(5) Contract C.4.01	**HSAG Required Evidence:** • Policies and procedures • Process for generating a paper copy of the provider directory • Copy of provider directory in Word or PDF format (excerpts are acceptable) • Link to the online provider directory • Staff training materials • HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the MCO:** • IA_ME.02 Provider Directory Policy pg. 1 II Policy. 1. Subsection a. • IA_Molina Paper Provider Directory Process. Entire document. • IA POD Link. Entire document. • IA POD Data Elements • Staff training is under development and will include the Provider Directory Policy and Paper Provider Directory Process.	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• A Word or PDF version of the provider directory is not yet available and will be provided at the on-site review	
MCO Description of Process: Molina Healthcare of Iowa will make the provider directory available in paper form upon request in accordance with the Provider Directory Policy. See Provider Directory Checklist. Note: Molina will provide a paper copy of the provider directory during on-site readiness. IA POD Link will include Iowa once approved.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** Although the MCO submitted the data elements that would be included in the provider directory, including office/facility accommodations for people with physical disabilities, HSAG strongly recommends that the MCO review the federal register regarding CMS' expectation pertaining to inclusion of accessibility accommodations. Additionally, HSAG recommends that the MCO consider requiring its providers (at the time of credentialing or other process) to report specific office/facility accommodations instead of on a voluntary basis. Further, the May 12, 2023 demonstration of the online provider directory suggested there may be a data mapping issue related to board certification and hospital affiliations. As such, HSAG strongly recommends the MCO validate that all provider directory components are pulling from the data sources appropriately.		
Required Actions: None.		
18. Information included in the MCO's paper provider directory is updated at least: a. Monthly, if the MCO does not have a mobile-enabled electronic provider directory; or b. Quarterly, if the MCO has a mobile-enabled electronic provider directory. 42 CFR §438.10(h)(3)(i) Contract C.4.02(a)	**HSAG Required Evidence:** • Policies and procedures • Verification of a mobile-enabled electronic provider directory • Workflow for updating paper provider directories • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.02 Provider Directory Policy pg. 1 II Policy. 1. Subsection b. • IA Mobile Enabled Prov Director Verification. Entire document. • IA_Workflow for Updating Provider Directory. Entire document. • Staff training materials are still under development but will consist of the Provider Directory Policy.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will update the paper provider directory per the policies and procedures.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
19. Information included in the MCO's electronic provider directory is updated no later than 30 calendar days after the MCO receives updated provider information. 42 CFR §438.10(h)(3)(ii) Contract C.4.02(b)	**HSAG Required Evidence:** • Policies and procedures • Workflow for updating the electronic provider directory • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.02 Provider Directory Policy pg. 1 II Policy. 1. Subsection b. • IA-Provider data in POD End to End Process_V2. Entire document. • Staff training is under development and will include the Provider Directory Policy.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will update the information in the provider directory within 30 days of receiving information provider information per the Provider Directory Policy.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
20. The MCO's provider directory is made available on the MCO's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(h)(4) Contract C.4.03	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable provider directory (e.g., .JSON format) • Link to the machine-readable provider directory on website **Evidence as Submitted by the MCO:** • IA_ME.02 Provider Directory Policy pg. 1 II Policy. 1. Subsection c. • IA Link to Machine-Readable Provider Directory. Entire document. Iowa will be added by on-site	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa has documented Policy and Procedures for the Provider Directory. Machine readable provider directory-This is demonstrated through our policy and procedure and will be demonstrated onsite as our provider directory is under development. Execution date is planned by 4/1/2023. Molina Healthcare of Iowa has provided a link to the machine-readable provider directory. Note: Iowa is currently not listed and will be added prior to on-site readiness.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Formulary		
21. The MCO makes available in electronic or paper form the following information about its formulary: a. Which medications are covered (both generic and name brand). b. What tier each medication is on. 42 CFR §438.10(i)(1-2) 42 CFR §438.10(c)(5) Contract C.5.01(a-b)	**HSAG Required Evidence:** • Policies and procedures • Copy of formulary in Word or PDF format (excerpts are acceptable) • Link to the online formulary **Evidence as Submitted by the MCO:** • IA_Prescription Drug Benefit Services_Addendum pg. 1 III State Variances Reference Table • IA_PDL URL. Entire document. • IA_web-pdl_final. Entire document.	☒ Met ☐ Not Met
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
22. The MCO's formulary drug list is made available on the MCO's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(i)(3) Contract C.5.01(c)	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable formulary (e.g. .JSON format) • Link to the machine-readable formulary on website **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• IA_Prescription Drug Benefit Services_Addendum pg. 1 III State Variances Reference Table • IA_PDL URL. Entire document. • IA_web-pdl_final. Entire document.	
MCO Description of Process: Note: Molina Healthcare of Iowa will make its PDL available and accessible to members on its website. Link to machine-readable format on Molina website is not up yet but will be a link to Iowa PDL file.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Electronic Materials and Communications		
23. Member information required in 42 CFR §438.10 may not be provided electronically unless the MCO meets all of the following: a. The format is readily accessible. b. The information is placed in a location on the MCO's website that is prominent and readily accessible. c. The information is provided in an electronic form which can be electronically retained and printed. d. The information is consistent with the content and language requirements of 42 CFR §438.10. e. The member is informed that the information is available in paper form without charge upon request and provides it upon request within five (5) business days. 42 CFR §438.10(c)(6) Contract C.8.01	**HSAG Required Evidence:** • Policies and procedures • Workflow for disseminating member materials • List of all materials that are only provided electronically • Link to website • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 3 II Policy. Section F. Subsection a-e. • IA Workflow Member Materials. Entire document. • IA Screenshot of website. Entire document. • Staff training is under development and will include the Member Communications Policy.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa does not exclusively provide member materials electronically. All member materials provided electronically are available upon request in a format requested by the member (such as print) as described in Molina's Member Communication Policy pg. 3 Section G.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
24. *The MCO leverages technology to promote timely, effective, and secure communications with members.* a. *Once a member selects a communication pathway, the MCO confirms that choice through regular mail with instructions on how to change the selection if desired.* b. *The MCO maintains the means to receive communication from members electronically, including via mail and website.* c. *The MCO responds to electronic inquiries within one (1) business day.* d. *The MCO is encouraged to utilize mobile technology, such as electronic delivery of medication and appointment reminders.* Contract C.8.02	**HSAG Required Evidence:** • Policies and procedures • Member materials with information on the modes by which members can communicate with the MCO • Mechanism for tracking members' preferred communication pathway (e.g., screenshot of system) • Screenshot of the messaging option on the member website • Mobile application workflows (e.g., text message reminders) • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy pg. 4 Section M. • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 3 Welcome and pg. 4. Important Contact Information • IA Mobile application workflows. Entire document. • IA_Mechanism Mem Communication Pathway_Messaging. Entire document. • Staff training is under development and will include the Member Communications Policy.	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa uses mobile technology to communicate with members. Such communication includes mobile applications and secure messaging.		
HSAG Findings: Although the MCO provided a demonstration of its member portal in the testing environment, the MCO indicated that the member portal will not be in production until June 2023.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Provide confirmation that the Iowa member portal is in production.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Member Website and Mobile Applications		
25. *The MCO maintains member websites and mobile applications available in English and Spanish that are accessible via cell phone.* a. *The website must include at a minimum all information made available for new members.* b. *The provider network information available via the member website must be searchable.* Contract C.8.03	**HSAG Required Evidence:** • Policies and procedures • Link to member website • Confirmation member website is available via English and Spanish • Confirmation of a mobile application of the member website • Link to provider network information available via the member website • Staff training materials **Evidence as Submitted by the MCO:** • IA Link to member website. Entire document. • IA Confirmation member website is available via English and Spanish. Entire document. • IA Confirmation of a mobile application of the member website. Entire document. • IA Provider network member website. Entire document. The Iowa Provider network directory is under development. • IA_ME.01-Member Communication Policy pg. 4 Section K. • Staff training is under development and will include the Member Communications Policy.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will maintain both a website and mobile application in English and Spanish. The website will be accessible vial cell phone and include new member information. The provider directory will be available and be searchable. Note: Member website is under development and will have all required information prior to on-sire readiness.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
New Member Communications		
26. *In addition to information set forth in Contract Sections C.1.01 and C.1.02, the enrollment materials include all information on the New Member Communications Checklist.* Contract C.1.03	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and welcome packet • HSAG will also use the results of the New Member Communications Checklist **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 2. II Policy. Section B. Subsections a-m. • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023. Entire document.	☒ Met ☐ Not Met
MCO Description of Process: All Molina Healthcare of Iowa's enrollment materials will include all information set forth in the New Member Communications Checklist.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Health Education and Initiatives		
27. *The MCO's communication initiatives include information on programs and how members can participate in activities to enhance the general health and well-being of members.* a. *The MCO develops a strategy to participate in and interface with the Healthiest State Initiative.* b. *The MCO develops an approach to support the Mental Health and Disability Services (MHDS) Redesign.* Contract C.1.04	**HSAG Required Evidence:** • Policies and procedures • Initiatives and programs for how members can participate in activities to enhance their health and well-being • Member informational materials on the initiatives and programs • Strategy supporting the Healthiest State Initiative • Approach to support the MHDS Redesign **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 4. II Policy. Section M. Subsection d.	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• IA_Iowa Quickstart Guide pg. 2 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 36 Value Added Services. Subsection: Health education for chronic conditions and healthy lifestyles • IA Healthiest State Initiative Strategy. Entire document. • IA_MHDS Region Collaboration Plan Description IA_20221228. Entire document. • IA_2023 VAB Sales Flyer Updates_Member. Entire Document. • Staff training is under development and will include the Member Communications Policy, the MHDS Region Collaboration Plan, and the Healthiest State Initiative Strategy.	
MCO Description of Process: Molina Healthcare of Iowa's overall strategy to improve the health and well-being of our members include support to the Mental Health and Disability Redesign, and the Healthiest State Initiative. Health information for members can be found in both the Member Handbook and Quickstart Guide.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Cost and Quality Information		
28. *The MCO implements and adheres to innovative strategies to provide price and quality transparency to members.* a. *The MCO makes cost and quality information available to members in order to facilitate more responsible use of health care services and inform health care decision-making.* Contract C.1.05	**HSAG Required Evidence:** • Policies and procedures • Member informational materials on cost and quality information **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 3. II Policy. Section D. • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 34-35 Member Costs and pg. 82 Other Plan	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	Details Subsection: Our Quality Improvement Plan and Program	
MCO Description of Process: Molina Healthcare of Iowa will utilize member materials such as the Member Handbook to inform members of healthcare costs and applicable cost-sharing responsibilities on pg. 34-35 of the Member Handbook. Molina also has a Quality Improvement Plan Program focused on ensuring quality of care for members. Information about this program can be found on pg. 82		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Implementation Support		
29. *The MCO publicizes methods for members to obtain support and ask questions during program implementation, including information on how to contact the Ombudsman and the MCO via the Member Services Hotline.* Contract C.1.09	**HSAG Required Evidence:** • Policies and procedures • Member informational materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy. Pg. 4. II Policy. Section J. • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 4 Important Contact Information and pg. 73 Ombudsman	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will publicize ways for members to get support and ask questions during implementation via the Member Handbook. Contact information is located throughout for visibility. Information on the Ombudsman can be found on page 71. Staff training is under development and will include the Member Communications Policy and the Member Handbook.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Member Services Helpline		
30. *The MCO maintains a Member Services Helpline that complies with the Member Services Helpline Checklist.*	**HSAG Required Evidence:** • Policies and procedures • Member informational materials	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Contract C.1.10–C.1.16	• Member Services Helpline communication workflows • Member Services Helpline staff training program/topics • Member Services Helpline monitoring plan for call center performance metrics • Member Services Helpline back-up plan • Member Services Helpline testing plan/results • Member Services Helpline call scripts • Staff training materials • HSAG will also use the results of the Member Services Helpline Checklist	
	Evidence as Submitted by the MCO: • See Member Services Helpline Checklist. • IA_ MHI_SYSTEM PROBLEM RESOLUTION, ESCALATION AND CHANGE MANAGEMENT PLAN.docx • IA_Business Continuity and Disaster Recovery Standard_ITS-003.01 IA State Addendum.docx • IA_Medicaid Member Phase 2 Call Flow.docx • IA_Member Phase 1 Call Flow .docx • IA_MHI Disaster Recovery Plan .docx • IA_MPCC Policy MHI-MPCC-2 - Interpreter Services and Special Needs.docx • IA_MPCC_2_Procedure_Interpreter Services and Special Needs.docx • IA_MPCC_3 Procedure_Call Center Requirements (KPI)_Medicaid.docx • IA_MPCC_3.2_Procedure_Call Center Requirements (KPI)_Medicaid.docx • IA_MPCC_3_Policy_Call Center Requirements (KPI).docx • IA_MPCC_4_Procedure_Hours of Operation.docx	

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• IA_MPCC_6_Procedure_MSR Training.docx • IA_MPCC-3.1_Policy State Addendum MHI.docx • IA_MPCC-4 Policy Hours of Operation.docx • IA_MPCC-4.1_Policy State Addendum MHI.docx • IA_UAT Test Script.docx • IA_Policy MPCC-6 MSR Training.docx • IA_Policy State Addendum MHI-MPCC-6.1.dox • IA_Warm Transfers Procedure.docx • IA_Greeting and Closing Script.pdf – Export from system • Staff training materials are under development.	
MCO Description of Process: See Member Services Helpline Checklist. Molina will comply with all elements within.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Nurse Call Line		
31. *The MCO operates a toll-free Nurse Call Line which provides nurse triage telephone services for members to receive medical advice twenty-four (24) hours a day/seven (7) days a week from trained medical professionals.* a. *The Nurse Call Line is well publicized and designed as a resource to members to help discourage inappropriate emergency room use.* b. *The Nurse Call Line has a system in place to communicate all issues with the member's health care providers, as applicable.* c. *The MCO has a written protocol specifying when a physician must be consulted in response to a call received.* d. *Calls requiring a medical decision are forwarded to the on-call physician, and a response to each call which requires a*	**HSAG Required Evidence:** • Policies and procedures • Member informational materials • Nurse Call Line communication workflows • Nurse Call Line and on-call physician schedule • Tracking mechanism for monitoring timely responses to medical decisions • Staff training materials **Evidence as Submitted by the MCO:** • IA_HCS.1.00_Nurse Advice Line Policy pg. 1 Section III Policy Paragraph 1 and pg. 1 and 2 Paragraph 5 Subsections a-g	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
medical decision is provided by the physician within thirty (30) minutes. Contract C.1.17	• IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 4 Important Contact Information • IA_UM Nurse and Medical Director on Call Schedule Template 2023. Entire document. • IA Triage Summary Report December 2022. Entire document. • IA StaffTrainingProgram. Entire document.	
MCO Description of Process: Molina Healthcare of Iowa has a system in place to operate a Nurse Advice Line 24 hours a day/7 day a week. On call physician and nurse schedules will be posted in advance. Molina Healthcare of Iowa has mechanisms in place to track timely responses for medical decisions.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Redetermination Process		
32. *The MCO assists its members in the eligibility redetermination process. The MCO conducts the following redetermination assistance activities:* a. *Conducts outreach calls or sends letters to members reminding them to renew their eligibility;* b. *Assists the member in understanding the redetermination process; and* c. *Helps the member obtain required documentation and collateral verification needed to process the application.* Contract C.1.18	**HSAG Required Evidence:** • Policies and procedures • Redetermination reminder notice templates • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.05-Member Redetermination Policy pg. 1 Section A, B, and C • IA_Redetermination Letter_Draft. Entire document. • Staff training is under development and will consist of the Member Redetermination Policy.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will follow the process outlined in the Member Redetermination Policy (Page 1, Sections A, B, and C). Notification letters will be sent to members to help them understand the process of redetermination.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
33. *In providing redetermination assistance, the MCO does not engage in any of the following activities:* a. *Discriminate against members, including particularly high-cost members or members that have indicated a desire to change MCOs;* b. *Talk to members about changing MCOs; these calls shall be referred to the enrollment broker;* c. *Provide any indication as to whether the member will be eligible, as this decision is at the sole discretion of HHS;* d. *Engage in or support fraudulent activity in association with helping the member complete the redetermination process;* e. *Sign the member's redetermination form; or* f. *Complete or send redetermination materials to HHS on behalf of the member.* Contract C.1.18	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.05-Member Redetermination Policy pg. 1 Section D. • Staff training is under development and will consist of the Member Redetermination Policy.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will follow the policy for member redetermination.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Marketing		
34. The MCO complies with the requirements listed in the Marketing Checklist. 42 CFR §438.104 Contract C.7.01–C.7.04	**HSAG Required Evidence:** • Policies and Procedures • Marketing program/plan for Iowa • Examples of current and planned marketing materials • Staff training materials • HSAG will also use the results of the Marketing Checklist **Evidence as Submitted by the MCO:** • IA_CE.03.01-Marketing Procedure	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• IA_CE.03-Marketing Policy • IA_Marketing and Outreach Plan Final Draft • IA_Video_Audio Scripts_v2 • IA_Warming OOH Content_v2 • IA_Warming Billboard Design • IA_2023 VAB Sales Flyer Updates_Member • Staff training is under development and will consist of the Marketing Policy and Procedure, as well as, the Marketing and Outreach Plan.	
MCO Description of Process: Molina Healthcare of Iowa has created a comprehensive marketing plan that is consistent with our contract, as well as our regulatory obligations. We also have a Marketing Policy and Procedure to support our efforts. See Member Handbook Checklist for more details.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Stakeholder Engagement and Education		
35. *The MCO complies with the requirements listed in the Stakeholder Engagement and Education Checklist.* Contract F.12.02–F.12.10	**HSAG Required Evidence:** • Policies and procedures • Stakeholder Advisory Board Charter • Implementation plan to create the Stakeholder Advisory Board • Stakeholder education and engagement strategy • Tentative schedule for Stakeholder Advisory Board meetings (e.g., dates/times/location/agenda) • Template for Stakeholder Advisory Board meeting minutes • List of current and planned Stakeholder Advisory Board members (internal and external) • Staff training materials • HSAG will also use the results of the Stakeholder Engagement and Education Checklist	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCO: • IA_CE.01.01 Community Events, Partners and Other Safety Net Providers Procedure • IA_CE.04 LTSS Stakeholder Engagement Strategy • IA_LTSS Stakeholder Agenda and Meeting Minutes • IA_LTSS Stakeholder Charter • IA_LTSS Stakeholder Communication Policy • IA_Stakeholder Education Strategy • Staff training is under development and will consist of the Stakeholder Communication Policy and the Stakeholder Engagement Strategy.	
MCO Description of Process: See Stakeholder Engagement and Education Checklist. Molina Healthcare of Iowa has created a strategy to implement a Stakeholder Advisory Board. Tentative schedule is encompassed within our strategy. The overall make up of advisory board member has been developed, however, the individuals will be selected after members are assigned.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Billings and Collections		
36. *Once an Iowa Health and Wellness Plan Member is enrolled with the MCO, the MCO establishes mechanisms to:* a. *Track member completion of the healthy behaviors (i.e., completion of both the Health Risk Assessment and Wellness Exam); and* b. *Educate members on the importance and benefits of healthy behavior completion.* Contract F.8.05	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as member welcome packet and educational materials • Staff training materials • Tracking and reporting mechanisms **Evidence as Submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 11 Iowa Health and Wellness Plan Subsection: Healthy Behaviors for Iowa Health and Wellness Plan Members	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• IA_Health and Wellness Draft Policy pg. 1 Purpose • IA_Health and Wellness Draft Procedure pg. 2 Procedure A-J	
MCO Description of Process: Molina has policies and procedures to track and report the completion of the Health Risk Assessment and Wellness Exam. Our team will also educate members on the importance of completing healthy behaviors. Tracking and reporting mechanisms can be found within the IA Health and Wellness Draft Procedure.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
37. *The MCO imposes copayments for Iowa Health and Wellness Plan members in accordance with the State's 1115 waiver and Hawki members in accordance with the State's Children's Health Insurance Program (CHIP) State Plan.* a. *For all other enrolled populations, the MCO may elect, but is not required, to impose copayments as outlined in the State Plan.* b. *If the MCO elects to impose copayments it ensures compliance with the requirements outlined in section F.8.06 of the Contract.* c. *In addition, the MCO notifies HHS if it elects to impose any of the State Plan cost sharing.* Contract F.8.06	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Copayments imposed by the MCO • Notification to HHS of imposed State Plan cost sharing • Staff training materials **Evidence as Submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 11 Iowa Health and Wellness Plan Subsection Monthly Contributions and pg. 34 Member Costs Subsection: Copays • IA_Copayment Policy. Entire document. • Copayments imposed by the MCO – see Copayment Policy • Notification to HHS on State Plan cost sharing – N/A (see below) • Staff training – Will require appropriate staff to be trained in the policy and procedure with documentation.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa (Molina) is electing to only impose copayments for the Iowa Health and Wellness Plan members in accordance with the State's 1115 waiver and Hawki members in accordance with the State's Children's Health Insurance Program (CHIP) State Plan. Molina is not electing to impose any other copayments outlined in the State Plan, and accordingly, there is no notification necessary to HHS.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
38. *The MCO develops, implements, and adheres to policies and procedures to identify the provider to which Client Participation shall be paid by members enrolled in LTSS.* a. *The MCO implements mechanisms to communicate the Client Participation amount to providers and delegates the collection of Client Participation to providers.* b. *The MCO pays providers net of the applicable Client Participation amount.* Some members have a Client Participation (formerly known as "patient liability"), which must be met before Medicaid reimbursement for services is available. This includes members with income above the HHS-defined threshold and eligible for Medicaid on the following bases: (i) Members in an institutional setting; and (ii) Members in a 1915(c) HCBS Waiver. HHS has sole responsibility for determining the Client Participation amount and will notify the MCO of Client Participation via the LTSS file. Contract F.8.12	**HSAG Required Evidence:** • Policies and procedures • Client Participation workflow • Member materials • Provider materials, such as the provider manual and provider contract-Rich to do • Staff training materials **Evidence as Submitted by the MCO:** • IA_Claim-110 MLTSS Client Participation Automated Processing Policy Rev 2 DRAFT • IA CP Workflow • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 35 Member Costs Subsection: Member Liability/Client Participation and pg. 85 Client Participation • Provider Manual 020923 Pg. 12 and 26 • Staff Training Materials-IA_LTSS New Hire Training Agenda: Page 3 – this is the section where CM staff will be trained on the policy and procedure. All training materials currently in development.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will communicate Client Participation responsibilities and amounts to both Members and Providers, as well as pay providers net of the Client Participation amount, where applicable.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information						
Met	=	37	X	1	=	37
Not Met	=	1	X	0	=	0
Total	=	38	Total Score		=	37
				Total Score ÷ Total	=	97%

Standard II—Marketing Checklist		
Reference	**Required Components**	
42 CFR §438.104(b)(1)(i) Contract C.7.01(a)	1. The MCO does not distribute marketing materials without first obtaining HHS approval.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03-Marketing Policy pg. 1. I. Purpose • IA_CE.03.01-Marketing Procedure I. Purpose and II Policy Section 2. • IA_Marketing and Outreach Plan Final Draft pg. 3 Outreach and Materials Distribution Methods	
42 CFR §438.104(b)(1)(ii) Contract C.7.01(b)	2. The MCO distributes marketing materials to its entire service area as indicated in the Contract.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03-Marketing Policy pg. 1 II. Policy. 3.	
42 CFR §438.104(b)(1)(iii) Contract C.7.01(c)	3. The MCO does not seek to influence enrollment in conjunction with the sale or offering of any private insurance.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03-Marketing Policy pg. 1 II. Policy. 4.	
42 CFR §438.104(b)(1)(iv) Contract C.7.01(d)	4. The MCO does not directly or indirectly engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03-Marketing Policy pg. 1 II. Policy. 4.	
Contract C.7.02	5. *The MCO is encouraged to market its products to the general community and potential members.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03.01-Marketing Procedure II. Procedure. 7. Subsection a. • IA_Marketing and Outreach Plan Final Draft pg. 2 Summary of Molina's Marketing and Distribution Plan	
Contract C.7.02	6. *All marketing activities are provided at no additional cost to HHS.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03.01-Marketing Procedure II. Procedure. 3.	

Standard II—Marketing Checklist		
Reference	**Required Components**	
Contract C.7.02	7. *The MCO complies with all applicable laws and regulations regarding marketing by health insurance issuers.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03-Marketing Policy pg. 1. I. Purpose.	
Contract C.7.02	8. *The MCO obtains HHS approval for all marketing materials at least thirty (30) days or within the time frame requested by HHS, prior to distribution.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03.01-Marketing Procedure pg.1. I. Purpose • IA_CE.03-Marketing Policy pg.1. I. Purpose	
Contract C.7.03	9. *The MCO may market via mail and mass media advertising such as radio, television, and billboards.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03.01-Marketing Procedure. II. Procedure. Pg.1. Section 8. Subsection a. • IA_Marketing and Outreach Plan Final Draft pg. 4 Paid Media Advertising. Table A, pg. 5 New Market Strategy, and pg. 8 Creative Messaging Examples • IA_Warming Content OOH Content_v2 • IA_Video_Audio Scripts_v2	
Contract C.7.03	10. *Participation in community-oriented marketing such as participation in community health fairs is encouraged.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03.01-Marketing Procedure. II. Procedure. Pg. 1. Section 7. Subsection b. • IA_Marketing and Outreach Plan Final Draft pg 3. Outreach Materials and Distribution Methods	
Contract C.7.03	11. *Tokens or gifts of nominal value may be distributed at such events to potential members, so long as the MCO acts in compliance with all law and policy guidance regarding inducements in the Medicaid Program, including marketing provisions provided for in 42 CFR §438.104.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03-Marketing Policy pg.1 II. Policy. Section 1. • IA_CE.03.01-Marketing Procedure. II. Procedure Pg. 1 and 2 Section 8. Subsection c.	

Standard II—Marketing Checklist		
Reference	**Required Components**	
42 CFR §438.104(b)(2) Contract C.7.04	12. The MCO's marketing, including plans and materials, are accurate and do not mislead, confuse, or defraud recipients or HHS.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03-Marketing Policy. II. Pg. 1 Policy. Section 5.	
42 CFR §438.104(b)(2)(i) Contract C.7.04	13. The MCO's materials do not contain any assertion or statement (whether written or oral) that the recipient must enroll in the MCO to obtain benefits or to not lose benefits.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03-Marketing Policy II. Pg.1. Policy. Section 6.	
42 CFR §438.104(b)(2)(ii) Contract C.7.04	14. The MCO's materials do not contain any assertion or statement (whether written or oral) that the MCO is endorsed by CMS, the Federal or State government, or a similar entity.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.03-Marketing Policy II. Pg. 1. Policy. Section 7.	

Standard II—Member Handbook Checklist		
Reference	**Required Components**	
The content of the member handbook includes information that enables the member to understand how to effectively use the managed care program. This information includes at a minimum:		
42 CFR §438.10(g)(2)(i) Contract C.2.02 Contract C.2.03 Contract C.2.04(a)	1. Benefits provided by the MCO, *including information about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits and how to access component services if individuals under age twenty-one (21) entitled to the EPSDT benefit are enrolled with the MCO.* **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 14 Covered Benefits and Services	Y ☒ N ☐
42 CFR §438.10(g)(2)(ii) Contract C.2.03 Contract C.2.04(b)	2. How and where to access any benefits provided by HHS, *including EPSDT benefits delivered outside of the MCO.* **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 14 Covered Benefits and Services and pg. 44 Wellness Care Subsection: Wellness Care for Children	Y ☒ N ☐
Contract C.2.03 Contract C.2.04(c)	**3.** *Cost sharing on any benefits carved out of the MCO's contract and provided by HHS.* **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 34 Member Costs. Subsection: Copays	Y ☒ N ☐
42 CFR §438.10(g)(2)(ii) Contract C.2.03 Contract C.2.04(d)	4. How transportation is provided, *including transportation for any benefits carved out of the MCO's contract and provided by HHS.* **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 23 Subsection: Transportation Benefits, pg. 36 Section: Value-Added Services. Subsection: Transportation, pg. 16 Covered Benefits and Services Table, and pg. 41 Value Added Services Table Subsection: Additional Transportation	Y ☒ N ☐
42 CFR §438.10(g)(2)(ii)(A) Contract C.2.03 Contract C.2.05(a) Contract C.8.06	5. In the case of a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO informs members that the service is not covered by the MCO. *Of note: if applicable, the MCO must notify members when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least 30 days prior to the effective date of the policy for any particular service.* **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 3 Welcome	Y ☐ N ☐ NA ☒

Standard II—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(ii)(B) 42 CFR §438.10(g)(2)(ii)(A) Contract C.2.03 Contract C.2.05(b)	6. The MCO informs members how they can obtain information from HHS about how to access the services not provided by the MCO because of moral or religious objections. **Evidence as submitted by the MCO:** • N/A Molina Healthcare of Iowa does not deny services based on moral or religious objections. (See above)	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(iii) Contract C.2.03 Contract C.2.06(a)	7. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 14 Covered Benefits and Services	Y ☒ N ☐
42 CFR §438.10(g)(2)(iv) Contract C.2.03 Contract C.2.06(b)	8. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 20 Subsection Prior Authorizations and pg. 14 Covered Benefits and Services	Y ☒ N ☐
42 CFR §438.10(g)(2)(v) Contract C.2.03 Contract C.2.07	9. The extent to which, and how, after-hours care is provided. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 28 Appointment Guidelines Table and pg. 32 Emergency and Urgent Care	Y ☒ N ☐
Contract C.2.03 Contract C.2.08(a)	10. *How emergency care is provided.* **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 32 Emergency and Urgent Care	Y ☒ N ☐
42 CFR §438.10(g)(2)(v)(A) Contract C.2.03 Contract C.2.08(b-c)	11. What constitutes an emergency medical condition and emergency services. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 32 Emergency and Urgent Care. Subsection: Emergencies and pg. 86 subsection Emergency Medical Condition and Emergency Services	Y ☒ N ☐

Standard II—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(v)(B) Contract C.2.03 Contract C.2.08(d)	12. The fact that prior authorization is not required for emergency services. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 21 Prior Authorizations	Y ☒ N ☐
42 CFR §438.10(g)(2)(v)(C) Contract C.2.03 Contract C.2.08(e)	13. The fact that the member has a right to use any hospital or other setting for emergency care. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 32 Emergency and Urgent Care. Subsection: Emergencies	Y ☒ N ☐
42 CFR §438.10(g)(2)(vi) Contract C.2.03 Contract C.2.09(a)	14. Any restrictions on the member's freedom of choice among network providers. **Evidence as submitted by the MCO:** • N/A	Y ☒ N ☐
42 CFR §438.10(g)(2)(vii) Contract C.2.03 Contract C.2.09(b) Contract C.2.10	15. The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the MCO cannot require members to obtain a referral before choosing a family planning provider. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 21 Prior Authorizations	Y ☒ N ☐
42 CFR §438.10(g)(2)(viii) Contract C.2.03 Contract C.2.11	16. Cost sharing. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 34 Member Costs and pg. 35 Subsection Member Liability/Client Participation	Y ☒ N ☐
42 CFR §438.10(g)(2)(ix) 42 CFR §438.100 Contract C.2.03 Contract C.2.12 Contract C.2.13	17. Member rights and responsibilities, including the elements specified in 42 CFR §438.100. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 65 and 66 Your Rights and Responsibilities Subsection: Your Rights and Subsection: Your Responsibilities	Y ☒ N ☐

Standard II—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(x) Contract C.2.03 Contract C.2.14	18. The process of selecting and changing the member's primary care provider. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 25 Going to the Doctor. Subsection: Picking Your Primary Care Provider	Y ☒ N ☐
42 CFR §438.10(g)(2)(xi)(A) Contract C.2.03 Contract C.2.16(a)	19. The right to file grievances and appeals. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 65 Your Rights and Responsibilities. Subsection: Your Rights.	Y ☒ N ☐
42 CFR §438.10(g)(2)(xi)(B) Contract C.2.03 Contract C.2.15 Contract C.2.16(b)	20. The requirements and time frames for filing a grievance or appeal. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 70 and 71 Appeals and Grievances. Subsection: How to file a grievance and subsection: How to file an appeal.	Y ☒ N ☐
42 CFR §438.10(g)(2)(xi)(C) Contract C.2.03 Contract C.2.16(c-d)	21. The availability of assistance in the filing process for grievances and appeals. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 70 Appeals and Grievances	Y ☒ N ☐
42 CFR §438.10(g)(2)(xi)(D) Contract C.2.03 Contract C.2.16(e)	22. The right to request a State fair hearing (SFH) after the MCO has made a determination on a member's appeal which is adverse to the member. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 72 Appeals and Grievances Subsection: State Fair Hearing	Y ☒ N ☐
42 CFR §438.10(g)(2)(xi)(E) Contract C.2.03 Contract C.2.15 Contract C.2.16(f)	23. The fact that, when requested by the member, benefits that the MCO seeks to reduce or terminate will continue if the member files an appeal or a request for an SFH within the time frames specified for filing, and that the member may, consistent with HHS policy, be required to pay the cost of services furnished while the appeal or SFH is pending if the final decision is adverse to the member. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 72-73 Appeals and Grievances. Subsection: Continuing Services during an Appeal or State Fair Hearing	Y ☒ N ☐

Standard II—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xii) 42 CFR §438.3(j)(3) Contract C.2.03 Contract C.2.17	24. How to exercise an advance directive, as set forth in 42 CFR §438.3(j). **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 76 Section Making a Living Will.	Y ☒ N ☐
42 CFR §438.10(g)(2)(xiii) Contract C.2.03 Contract C.2.18(a)	25. How to access auxiliary aids and services, including additional information in alternative formats or languages. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. V. Language Assistance and pg. 7 Accessibility. Subsection: Accessibility to Information	Y ☒ N ☐
42 CFR §438.10(g)(2)(xiv) Contract C.2.03 Contract C.2.18(b-d)	26. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 4 Section Welcome. Subsection: Important Contact Information	Y ☒ N ☐
42 CFR §438.10(g)(2)(xv) Contract C.2.03 Contract C.2.18(e)	27. Information on how to report suspected fraud or abuse. **Evidence as submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG pg. 77 Fraud, Waste, and Abuse	Y ☒ N ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
A member enrolled with the MCO has the following rights:		
42 CFR §438.100(b)(2)(i) Contract C.2.12(a) Contract F.16.01	1. Receive information in accordance with 42 CFR §438.10. **Evidence as submitted by the MCO:** • IA_ME.03-Member Rights and Responsibilities Policy: II Policy: 1: Subsection c • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 65 Section Your Rights and Responsibilities. Subsection: Your Rights. Bullet 2.	Y ☒ N ☐
42 CFR §438.100(b)(2)(ii) Contract C.2.12(b) Contract F.16.02	2. Be treated with respect and with due consideration for his or her dignity and privacy. **Evidence as submitted by the MCO:** • IA_ME.03-Member Rights and Responsibilities Policy: II Policy: 1: Subsection a • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 65 Section Your Rights and Responsibilities. Subsection: Your Rights. Bullet 1.	Y ☒ N ☐
42 CFR §438.100(b)(2)(iii) Contract C.2.12(c) Contract F.16.04	3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. **Evidence as submitted by the MCO:** • IA_ME.03-Member Rights and Responsibilities Policy: II Policy: 1: Subsection e • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 65 Section Your Rights and Responsibilities. Subsection: Your Rights. Bullet 10	Y ☒ N ☐
42 CFR §438.100(b)(2)(iv) Contract C.2.12(d) Contract F.16.05	4. Participate in decisions regarding his or her health care, including the right to refuse treatment. **Evidence as submitted by the MCO:** • IA_ME.03-Member Rights and Responsibilities Policy: II Policy: 1: Subsection f • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 65 Section Your Rights and Responsibilities. Subsection: Your Rights. Bullet 9	Y ☒ N ☐
42 CFR §438.100(b)(2)(v) Contract C.2.12(e) Contract F.16.06	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. **Evidence as submitted by the MCO:** • IA_ME.03-Member Rights and Responsibilities Policy: II Policy: 1: Subsection g • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 65 Section Your Rights and Responsibilities. Subsection: Your Rights. Bullet 12	Y ☒ N ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
42 CFR §438.100(b)(2)(vi) 45 CFR §164.524 45 CFR §164.526 Contract C.2.12(f) Contract F.16.07	6. If the privacy rule (as set forth in 45 CFR parts 160 and 164 subparts A and E) applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ME.03-Member Rights and Responsibilities Policy: II Policy: 1: Subsection h • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 65 Section Your Rights and Responsibilities. Subsection: Your Rights. Bullet 13	
42 CFR §438.100(b)(3) 42 CFR §438.206 42 CFR §438.210 Contract C.2.13	7. Be furnished healthcare services in accordance with 42 CFR §438.206 through §438.210.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ME.03-Member Rights and Responsibilities Policy: II Policy: 1: Subsection j • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 66 Section Your Rights and Responsibilities. Subsection: Your Rights. Bullet 25 and 26	
42 CFR §438.100(c) Contract F.16.08	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its network providers or HHS treat the member.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ME.03-Member Rights and Responsibilities Policy: II Policy: 1: Subsection i • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 66 Section Your Rights and Responsibilities. Subsection: Your Rights. Bullet 4	
42 CFR §438.100(d) 42 CFR §438.3(d)(3)(4) Contract J.2.01-J.2.02	9. The MCO complies with any other applicable federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ME.03-Member Rights and Responsibilities Policy: II Policy: 1: Subsection m • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 10 Nondiscrimination Language	

Standard II—Member Rights Checklist		
Reference	**Required Components**	
Contract F.16.03	10. *In recognizing each member's dignity and privacy, the MCO does not in any way restrict the member's right to fully participate in the community and to work, live, and learn to the fullest extent possible.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ME.03-Member Rights and Responsibilities Policy: II Policy: 1: Subsection b • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 65 Section Your Rights and Responsibilities. Subsection: Your Rights. Bullet 3 and 4, and page 66, Bullet 7	

Standard II—Member Services Helpline Checklist		
Reference	**Required Components**	
To facilitate the delivery of integrated healthcare services, the Member Services Helpline is used by all members, regardless of whether the member is calling about physical health, behavioral health, and/or long-term care services.		
Contract C.1.10	1. *The MCO does not have separate numbers for members to call regarding behavioral health and/or long-term care services.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_Member Phase 1 Call Flow pg. 1 Section 3 • IA_Medicaid Member Phase 2 Call Flow pg. 2 Section 11	
Contract C.1.10	2. *The MCO either routes the call to another entity or conducts a "warm transfer" to another entity, but the MCO does not require a member to call a separate number regarding behavioral health and/or long-term care services.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_Medicaid Member Phase 2 Call Flow pg. 2 Section 11	
Contract C.1.11	3. *The MCO maintains a dedicated toll-free Member Services Helpline staffed with trained personnel knowledgeable about the program.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_Policy MPCC-6 MSR Training pg. 1 Purpose	
Contract C.1.11	4. *Helpline staff are equipped to handle a variety of member inquiries.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_Policy MPCC-6 MSR Training pg. 1 Purpose and Policy • IA_MPCC_6_Procedure_MSR Training pg. 1 Procedure	
Contract C.1.11	5. *The telephone line is staffed with live-voice coverage during normal working days (Monday through Friday), excluding State holidays, and is accessible, at minimum, during working hours of 7:30 a.m.–6:00 p.m. Central Time (CT). The State holidays are:* a. *New Year's Day;* b. *Martin Luther King, Jr.'s Birthday;* c. *Memorial Day;* d. *July 4th;* e. *Labor Day;*	Y ☒ N ☐

Standard II—Member Services Helpline Checklist		
Reference	**Required Components**	
	f. *Veterans Day;* g. *Thanksgiving;* h. *Day after Thanksgiving; and* i. *Christmas Day.*	
	Evidence as submitted by the MCO: • IA_MPCC-4 Policy Hours of Operation pg. 1 Policy • IA_MPCC-4.1 Policy State Addendum MHI pg. 1. II Scope.	
Contract C.1.11	6. *The MCO provides a voice message system that informs callers of the MCO's business hours and offers an opportunity to leave a message after business hours.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_MPCC-4 Policy Hours of Operation pg. 1 Policy	
Contract C.1.11	7. *Calls received in the voice message system are returned within two (2) business days.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_MPCC-4 Policy Hours of Operation pg. 1 Policy	
Contract C.1.11	8. *The MCO has the ability to "warm transfer" members to outside entities, such as provider offices, and internal MCO departments, such as to care coordinators, to facilitate the provision of high quality customer service.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_Warm Transfers Procedure – Document is an export from the system	
Contract C.1.11	9. *The MCO ensures all calls are answered by live operators who identify themselves by name to each caller.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_Greeting and Closing Script pg. 1 Standard Greeting – Document is an export from the system	
Contract C.1.11	10. *The MCO may utilize an Interactive Voice Response (IVR) system but ensures a caller is connected to a live person within one (1) minute if the caller chooses that option.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_MPCC_3 Procedure_Call Center Requirements (KPI)_Medicaid pg. 2 Performance Standards Table	

Standard II—Member Services Helpline Checklist		
Reference	**Required Components**	
Contract C.1.12	11. *The MCO's Member Services Helpline complies at all times with the performance metrics set forth in Contract Section A.27.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_MPCC_3 Procedure_Call Center Requirements (KPI)_Medicaid pg. 2 Performance Standards Table • IA_MPCC-3.1_Policy State Addendum MHI	
Contract C.1.13	12. *The Member Services Helpline is available for all callers.* a. *The MCO maintains an operates telecommunication device for the deaf (TDD) services for hearing impaired members.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_MPCC Policy MHI-MPCC-2 - Interpreter Services and Special Needs pg.1 Policy Bullet 4	
Contract C.1.13	13. *The MCO ensures communication between the MCO and the member is in a language the member understands.* a. *In cases where a member's language is other than English, the MCO offers and, if accepted by the member, supplies interpretive services at no charge to the member.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_MPCC Policy MHI-MPCC-2 - Interpreter Services and Special Needs pg.1 Policy bullets 1 and 2 • IA_MPCC_2_Procedure_Interpreter Services and Special Needs pg. 1 Procedure Bullet 1	
Contract C.1.13	14. *Automated telephone menu options are made available in English and Spanish.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_Member Phase 1 Call Flow pg 3. Section 16. • IA_Medicaid Member Phase 2 Call Flow pg. 5 Section 21	
Contract C.1.14	15. *The MCO's Member Services Helpline staff are prepared to efficiently respond to member concerns or issues, including but not limited to:* a. *How to access health care services;* b. *Identification or explanation of covered services;* c. *Procedures for submitting a grievance or appeal;* d. *Reporting fraud or abuse;* e. *Locating a provider;*	Y ☒ N ☐

Standard II—Member Services Helpline Checklist		
Reference	**Required Components**	
	f. *Health crises, including but not limited to, suicidal callers;* g. *Balance billing issues;* h. *Cost-sharing and Client Participation inquiries;* i. *Primary care provider (PCP) change and/or initial attribution; and* j. *Incentive programs.*	
	Evidence as submitted by the MCO: • IA_MPCC_6_Procedure_MSR Training pg. 1 Procedure • IA_Policy State Addendum MHI-MPCC-6.1	
Contract C.1.15	16. *The MCO maintains a backup plan and system to ensure that, in the event of a power failure or outage, the following are in place and functioning:* a. *A back-up system capable of operating the telephone system, at full capacity, with no interruption of data collection;* b. *A notification plan that ensures HHS is notified when the MCO's phone system is inoperative or a back-up system is being utilized; and* c. *Manual back-up procedure to allow requests to continue being processed if the system is down.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ MHI_SYSTEM PROBLEM RESOLUTION, ESCALATION AND CHANGE MANAGEMENT PLAN • IA_Business Continuity and Disaster Recovery Standard_ITS-003.01 IA State Addendum • IA_MHI Disaster Recovery Plan	
Contract C.1.16	17. *The MCO maintains a system for tracking and reporting the number and type of member calls and inquiries it receives during business and non-business hours.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_MPCC-3.1_Policy_State Addendum MHI pg. 1 II. Scope.	
Contract C.1.16	18. *The MCO monitors its Member Services Helpline and reports its telephone service level performance to HHS in the time frames and according to the specifications described in the Reporting Manual.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_MPCC_3.2_Procedure_Call Center Requirements (KPI)_Medicaid • IA_MPCC-3.1_Policy State Addendum MHI pg. 1. II. Scope	

Standard II—New Member Communications Checklist		
Reference	**Required Components**	
The MCO distributes enrollment materials to each member and their authorized representative. The enrollment materials include the following information:		
Contract C.1.03(a)	1. *The MCO's contact information, including address, telephone number, website.* **Evidence as submitted by the MCO:** • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection a • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 4 Section: Welcome. Subsection: Important Contact Information	Y ☒ N ☐
Contract C.1.03(b)	2. *The MCO's office hours/days, including the availability of the Member Helpline and the twenty-four (24) hour Nurse Call Line.* **Evidence as submitted by the MCO:** • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection b • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 4 Section: Welcome. Subsection: Important Contact Information	Y ☒ N ☐
Contract C.1.03(c)	3. *Description of how to complete a health risk screening, a process described in Contract Section G.2.* **Evidence as submitted by the MCO:** • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection c • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 12 Section Iowa Health and Wellness Plan Subsection: Healthy Behaviors for IHAWP Members- Health Risk Assessment. • IA_Health Risk Assessment Instructions (This is included in the Member Welcome Kit)	Y ☒ N ☐
Contract C.1.03(d)	4. *If applicable, any cost-sharing information, including Client Participation responsibilities for 1915(c) Home and Community-Based Services (HCBS) waiver members, 1915(i) program members, Intermediate Care Facilities for individuals with Intellectual disability (ICF/ID), and Nursing Facility (NF) residents, and contact information where the member can ask questions regarding their cost-sharing obligations and consequences for failure to comply with cost sharing and Client Participation requirements.* **Evidence as submitted by the MCO:** • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection d • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 35 Member Costs Subsection: Member Liability/Client Participation	Y ☒ N ☐

Standard II—New Member Communications Checklist		
Reference	**Required Components**	
Contract C.1.03(e)	5. *Procedures for obtaining out-of-network services and any special benefit provisions (for example, co-payments, limits or rejections of claims) that may apply to services obtained outside the MCO's network.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection e • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 20 Prior Authorizations	
Contract C.1.03(f)	6. *Standards and expectations for receiving preventive health services.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection f • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 14 Covered Benefits and Services Table. Subsection: Preventative Services and pg. 33 Subsection: Routine Care.	
Contract C.1.03(g)	7. *Procedures for changing MCOs and circumstances under which this is possible, as described in Contract Section B.5.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection g • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023. Pg. 87. Subsection: Good Cause.	
Contract C.1.03(h)	8. *Procedures for making complaints and recommending changes in policies and services.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection h • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. iv and pg. 70 Section: Appeals and Grievances	
Contract C.1.03(i)	9. *Information on how to contact the Iowa Medicaid Enrollment Broker.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection i • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 4 Section: Welcome. Subsection: Important Contact Information	

Standard II—New Member Communications Checklist		
Reference	**Required Components**	
Contract C.1.03(j)	10. *Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats at no expense.* **Evidence as submitted by the MCO:** • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection j • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. V. Language Assistance and pg. 7 Accessibility. Subsection: Accessibility to Information.	Y ☒ N ☐
Contract C.1.03(k)	11. *Information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect.* **Evidence as submitted by the MCO:** • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection k • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 5 Section: Welcome. Subsection: Important Contact Information	Y ☒ N ☐
Contract C.1.03(l)	12. *Contact information and description of the role of the Ombudsman.* **Evidence as submitted by the MCO:** • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection l • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 73 and 74 Section: Ombudsman	Y ☒ N ☐
Contract C.1.03(m)	13. *For members enrolled in a 1915(c) HCBS Waiver or 1915(i) State Plan, the MCO also provides the following information:* a. *A description of the Community-Based Case Management's or Integrated Health Home (IHH) care coordinator's roles and responsibilities;* b. *Information on how to change Community-Based Case Management or IHH Care Coordination; and* c. *When applicable, information on the option to self-direct, a process described in Contract Section F.12D, including but not limited to:* i. *The roles and responsibilities of the member;* ii. *The ability of the member to select a representative;* iii. *The services that can and cannot be self-directed;* iv. *The member's right to participate and voluntarily withdraw;*	Y ☒ N ☐

Standard II—New Member Communications Checklist		
Reference	**Required Components**	
	v. *How to select the self-direction option;* vi. *Who can and cannot be hired by the member to perform the services; and* vii. *Information on estate recovery.*	
	Evidence as submitted by the MCO: • IA_ME.01-Member Communication Policy pg. 2 II Policy B. Subsection m • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 49 Section: LTSS Subsection: Case Management and pg. 62 Section: Integrated Health Home	

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
The MCO makes available in paper form upon request and electronic form, the following information about its network providers:		
42 CFR §438.10(h)(1)(i) Contract C.4.01(a)	1. The provider's name as well as any group affiliation. **Evidence as submitted by the MCO:** • POD Data elements attached (First Tab Row 13, 16, 20, 21, 22, 26, 29) • IA_ME.02 Provider Directory Policy pg. 1 II Policy 2. Subsection a	Y ☒ N ☐
42 CFR §438.10(h)(1)(ii) Contract C.4.01(b)	2. Street address(es). **Evidence as submitted by the MCO:** • POD Data elements attached (First Tab Row 17, 18, 32, 36) • IA_ME.02 Provider Directory Policy pg. 1 II Policy 2. Subsection b	Y ☒ N ☐
42 CFR §438.10(h)(1)(iii) Contract C.4.01(c)	3. Telephone number(s). **Evidence as submitted by the MCO:** • POD Data elements attached (First Tab Row 35) • IA_ME.02 Provider Directory Policy pg. 2 II Policy 2. Subsection c	Y ☒ N ☐
42 CFR §438.10(h)(1)(iv) Contract C.4.01(d)	4. Website uniform resource locater (URL), as appropriate. **Evidence as submitted by the MCO:** • POD Data elements attached (First Tab Row 40) • IA_ME.02 Provider Directory Policy pg. 2 II Policy 2. Subsection d	Y ☒ N ☐
42 CFR §438.10(h)(1)(v) Contract C.4.01(e)	5. Specialty, as appropriate. • POD Data elements attached (First Tab Row 9, 11, 12, 27, 29, 42, 44) • IA_ME.02 Provider Directory Policy pg. 2 II Policy 2. Subsection e	Y ☒ N ☐
42 CFR §438.10(h)(1)(vi) Contract C.4.01(f)	6. Whether the provider will accept new members. **Evidence as submitted by the MCO:** • POD Data elements attached (First Tab Row 2) • IA_ME.02 Provider Directory Policy pg. 2 II Policy 2. Subsection f	Y ☒ N ☐

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
42 CFR §438.10(h)(1)(vii) Contract C.4.01(g)	7. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office.	Y ☒ N ☐
	Evidence as submitted by the MCO: • POD Data elements attached (First Tab Row 10, 25, 45) • IA_ME.02 Provider Directory Policy pg. 2 II Policy 2. Subsection g	
42 CFR §438.10(h)(1)(viii) Federal Register Vol. 81 No.88 (FR 27729) Contract C.4.01(h)	8. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment.	Y ☒ N ☐
	Evidence as submitted by the MCO: • POD Data elements attached (First Tab Row 6, 19) • IA_ME.02 Provider Directory Policy pg. 2 II Policy 2. Subsection h	
42 CFR §4358.10(h)(2) Contract C.4.01	9. The provider directory components are included for following provider types covered under the contract: a. Physicians, including specialists; b. Hospitals; c. Pharmacies; d. Behavioral health providers; and e. Long-term services and supports (LTSS) providers, as appropriate.	Y ☒ N ☐
	Evidence as submitted by the MCO: • POD Data elements attached • IA_ME.02 Provider Directory Policy pg. 1 II Policy 2.	

Standard II—Stakeholder Engagement and Education Checklist		
Reference	**Required Components**	
Contract F.12.03	1. *The MCO develops a comprehensive member and stakeholder education and engagement strategy to ensure understanding of the program and to promote a collaborative effort to enhance the delivery of high-quality services to members.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy	
Contract F.12.03	2. *Representatives from the MCO participates in HHS-sponsored outreach and education activities as requested by HHS.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.01.01 Community Events Procedure. Procedure number 2	
Contract F.12.03	3. *The MCO documents its strategy in the Policies and Procedures Manual (PPM).*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy	
42 CFR §438.110(a) Contract F.12.04	4. The MCO convenes a Stakeholder Advisory Board in accordance with the requirements of 42 CFR §438.110.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy • IA_LTSS Stakeholder Charter pg. 1. Purpose of Committee	
Contract F.12.04	5. *The MCO establishes and maintains a Stakeholder Advisory Board within ninety (90) days of the effective date of the Contract.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy	
Contract F.12.04	6. *The purpose of the Stakeholder Advisory Board is to serve as a forum for members or their representatives and providers to advise the MCO.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy. Goal 1. • IA_LTSS Stakeholder Charter pg. 2 Structure.	

Standard II—Stakeholder Engagement and Education Checklist		
Reference	**Required Components**	
Contract F.12.04	7. *The Stakeholder Advisory Board provides input on issues such as:* *a. Service delivery;* *b. Quality of care;* *c. Member rights and responsibilities;* *d. Resolution of grievances and appeals;* *e. Operational issues;* *f. Program monitoring and evaluation;* *g. Member and provider education; and* *h. Priority issues identified by members.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy. Page 3 Purpose and pg. 5 under Goal 4	
Contract F.12.05	8. *The Stakeholder Advisory Board is comprised of members' representatives of the different populations enrolled in the program, family members and providers.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy Pg 1 • IA_LTSS Stakeholder Charter pg. 1	
Contract F.12.05	9. *The Stakeholder Advisory Board has an equitable representation of its members in terms of race, gender, special populations, and Iowa geographic areas.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy. Page 5 under Goal 4. • IA_LTSS Stakeholder Charter pg. 1	
Contract F.12.05	10. *At least fifty-one (51) percent of the Stakeholder Advisory Board is comprised of members and/or their representatives (e.g., family members or caregivers), including members receiving long-term services and supports (LTSS).*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy. Page 1 Goal 2	

Standard II—Stakeholder Engagement and Education Checklist		
Reference	**Required Components**	
Contract F.12.05	11. *Provider membership is representative of the different services covered under the Contract, including, but not limited to LTSS, primary care, and behavioral health providers.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy. Goal 1. First bullet	
Contract F.12.06	12. *The MCO maintains written documentation of all attempts to invite and include members in the Stakeholder Advisory Board meetings.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_LTSS Stakeholder Communication Policy pg. 1. (B)	
Contract F.12.06	13. *The MCO maintains meeting minutes, which are made available to HHS upon request.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA LTSS Stakeholder Agenda and Meeting Minutes • IA_LTSS Stakeholder Communication Policy pg. 1. (C)	
Contract F.12.06	14. *The MCO reports to HHS on participation rates, engagement strategies and outcomes of the committee process in the time frame and manner prescribed by HHS in the Reporting Manual.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_LTSS Stakeholder Communication Policy pg. 1. (D)	
Contract F.12.07	15. *The MCO implements strategies to facilitate member participation in the Stakeholder Advisory Board meetings, including, but not limited to, alternative means of remote participation such as video or conference call and through the provision of transportation, interpretation services, and personal care assistance.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_LTSS Stakeholder Communication Policy pg. 1. (A)	
Contract F.12.08	16. *The MCO convenes the Stakeholder Advisory Board, at minimum, on a quarterly basis and in regions throughout the State.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy. Goal 2 • IA_LTSS Stakeholder Charter pg. 3	

Standard II—Stakeholder Engagement and Education Checklist		
Reference	**Required Components**	
Contract F.12.08	17. *The MCO advises HHS of all meetings at least fifteen (15) days in advance of the meeting.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_LTSS Stakeholder Communication Policy pg. 1. (E)	
Contract F.12.09	18. *The MCO utilizes feedback obtained from the Stakeholder Advisory Board in the development and implementation of process improvement strategies and to inform policy and procedure development and modification.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy. Page 1 under Goal 3. • IA_LTSS Stakeholder Charter pg. 1	
Contract F.12.09	19. *Issues raised by stakeholders are incorporated into the MCO's quality assessment and performance improvement (QAPI) program, and into other MCO operational planning and management activities as indicated by the nature of the input.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy. Page 1 under Goal 4 • IA_LTSS Stakeholder Charter pg. 2	
42 CFR §438.110(b) Contract F.12.10	20. The Stakeholder Advisory Committee includes at least a reasonably representative sample of the LTSS populations, or other individuals representing those members, covered under the Contract.	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CE.04 LTSS Stakeholder Engagement Strategy. Page 5 under Goal 4. • IA_LTSS Stakeholder Charter pg. 1. Purpose of Committee	

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Definitions		
1. The MCO defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. 42 CFR §438.114(a) Contract Exhibit B: Glossary of Terms/Definitions	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS-302 Post Stabilization Services Policy- V. Definitions page 3 • IA Combined Roles and CRP Detailed Agenda – entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Agenda – entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Agenda – entire document • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 32 and page 86 • IA Provider Manual 020923 page 37 and 49	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") defines emergency medical conditions in alignment with 42 CFR 438.114 (a). Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
2. The MCO defines "emergency services" as covered inpatient and outpatient services that are as follows: a. Furnished by a provider that is qualified to furnish these services under Title 42.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials	☒ Met ☐ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
b. Needed to evaluate or stabilize an emergency medical condition. 42 CFR § 438.114(a) Contract Exhibit B: Glossary of Terms/Definitions	**Evidence as Submitted by the MCO:** • IA HCS-302 Post Stabilization Services Policy- V. Definitions page 3 • IA Combined Roles and CRP Detailed Agenda – entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 – entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 – entire document • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 32 • IA Provider Manual 020923 page 36 and 49	
MCO Description of Process: Molina Healthcare of Iowa defines emergency services in alignment with 42 CFR 438.114 (a). Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
3. The MCO defines "poststabilization care services" as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition. 42 CFR §438.114(a) Contract Exhibit B: Glossary of Terms/Definitions	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS-302 Post Stabilization Services Policy- V. Definitions page 3 • IA Combined Roles and CRP Detailed Agenda – entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 – entire document	☒ Met ☐ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• IA CRC PA Role Specific NEO Agenda 12-5-23 – entire document • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 33 • IA Provider Manual 020923, page 47	
MCO Description of Process: Molina Healthcare of Iowa defines post-stabilization care services in alignment with 42 CFR 438.114 (a). Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Coverage and Payment		
4. The MCO covers and pays for emergency services regardless of whether the provider that furnishes the services *is Iowa Medicaid enrolled or* has a contract with the MCO. a. *The MCO must provide emergency services without requiring a primary care provider (PCP) referral.* 42 CFR §438.114(c)(1)(i) Contract F.1.05(a) Contract F.1.08	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim algorithm for emergency services • Staff training materials • HSAG will use results from the mock claims demonstration **Evidence as Submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 32 • IA Provider Manual 020923 page 37 • Claims Adjudication Procedure- Emergency Services (SP) (Claim algorithm for emergency services) – entire document • Life of a Claim(SP) – page 1	☒ Met ☐ Not Met
MCO Description of Process: Molina covers and pays for emergency services regardless of whether the provider that furnishes the services *is Iowa Medicaid enrolled or* has a contract with the MCO. Staff training are being developed using claims adjudication procedure and Life of a Claim.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
5. *The MCO makes emergency services available twenty-four (24) hours a day, seven (7) days a week.* a. *The MCO pays non-contracted and/or non-Iowa Medicaid enrolled providers for emergency services at the amount that would have been paid if the service had been provided under HHS' fee-for-service Medicaid program.* Contract F.1.04	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim algorithm for emergency services • Staff training materials **Evidence as Submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 32 • IA Provider Manual 020923 page 37 • Claims Adjudication Procedure – Emergency services (Claim algorithm for emergency services) – page 1	☒ Met ☐ Not Met
MCO Description of Process: Molina pays non-contracted and/or non-Iowa Medicaid enrolled providers for emergency services at the amount that would have been paid if the service had been provided under HHS' fee-for-service Medicaid program. Staff training are being developed using claims adjudication procedure and Life of a Claim.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
6. *While the MCO is required to reimburse providers for the screening examination, the MCO is not required to reimburse providers for non-emergency services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard.* a. *The MCO does not deny or pay less than the allowed amount for the Current Procedural Terminology (CPT) code on the claim without a medical record review to determine if the prudent layperson standard was met.*	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim algorithm for emergency services, including any edits for prudent layperson review • Staff training materials **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
b. *The MCO bases coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson, even if the condition turned out to be non-emergency in nature.* c. *The prudent layperson review is conducted by a MCO staff member who does not have medical training.* d. *The MCO does not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard.* Contract F.1.02	• IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 "Emergency and Urgent Care" page 32 • IA Provider Manual 020923 page 37 • Claims Adjudication Procedure-Emergency Services (SP) (Claim algorithm for emergency services) – page1	
MCO Description of Process: If Molina is required to reimburse providers for the screening examination, Molina is not required to reimburse providers for non-emergency services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard. 1. Molina does not deny or pay less than the allowed amount for the Current Procedural Terminology (CPT) code on the claim without a medical record review to determine if the prudent layperson standard was met. 2. Molina bases coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson, even if the condition turned out to be non-emergency in nature. 3. The prudent layperson review is conducted by a Molina staff member who does not have medical training. 4. Molina does not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard. 5. Staff training are being developed using claims adjudication procedure and Life of a Claim.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
7. The MCO does not deny payment for treatment obtained under either of the following circumstances: a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in the definition of "emergency medical condition." b. A representative of the MCO instructs the member to seek emergency services. 42 CFR §438.114(c)(1)(ii) Contract F.1.05(b-c)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services • Staff training materials **Evidence as Submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 32 • IA Provider Manual 020923 page 37 • Claims Adjudication Procedure-Emergency Services (Claim algorithm for emergency services) – page 2	☒ Met ☐ Not Met
MCO Description of Process: Molina does not deny payment for treatment obtained in circumstances where a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in the definition of "emergency medical condition, or a representative of Molina instructs the member to seek emergency services. Staff training are being developed using claims adjudication procedure and Life of a Claim.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Additional Rules for Emergency Services		
8. The MCO does not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the MCO, or applicable State entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services • Staff training materials **Evidence as Submitted by the MCO:** • a. - IA HCS-302 Post Stabilization Services Policy II B. 1page 2	☒ Met ☐ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.114(d)(1) Contract F.1.06	• IA Combined Roles and CRP Detailed Agenda – entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 – entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 – entire document • A_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 32 • IA Provider Manual 020923 page 37 • Claims Adjudication Procedure-Emergency Services (Claim algorithm for emergency services) – page 1	
MCO Description of Process: Molina Healthcare of Iowa does not limit what constitutes an emergency medical condition to a list of diagnoses or symptoms. Molina Healthcare of Iowa does not refuse coverage for emergency services based on the emergency room provider, hospital, or lack of notice to primary care provider, Molina, or State entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. ER services do not require notification from primary care provider, Molina, or state entity in order to get paid. Staff trainings are being developed using claims adjudication procedure and Life of a Claim and UM agendas and the UM program description and UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
9. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. 42 CFR §438.114(d)(2) Contract F.1.03 Contract F.1.07	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency and poststabilization services • Staff training materials **Evidence as Submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 32 • IA Provider Manual 020923 page 38	☒ Met ☐ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• Claims Adjudication Procedure-Emergency Services (Claim algorithm for emergency services) – page 2	
MCO Description of Process: Molina members who have an emergency medical condition will not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. Staff training are being developed using claims adjudication procedure and Life of a Claim.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
10. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO. 42 CFR §438.114(d)(3) Contract F.1.09	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS-302 Post Stabilization Services Policy II. B. 2 page 2 • IA Combined Roles and CRP Detailed Agenda – entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 – entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 – entire document • IA Provider Manual 020923 page 38	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's policy states that only the attending physician or the provider who is treating the member can determine when the member is stable for discharge or transfer. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** The MCO submitted its HCS-302 Post Stabilization Services policy, which contained the federal poststabilization services language verbatim. However, although the policy is named Post Stabilization Services, the purpose indicated that the policy applied to emergency, urgent care, and stabilization service requests, in addition to poststabilization service requests. The policy section also did not appear to relate directly to the purpose of the policy as it indicated, "In accordance with the Hospital Service Agreement, Molina Healthcare of Iowa shall coordinate telephonic, on-site, and electronic utilization		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
review with hospital facility staff on inpatient admissions of Molina Healthcare of Iowa members concurrent with the admission. Molina Healthcare of Iowa requires clinical review of all medical necessity decisions. All Molina Healthcare of Iowa professionals reviewing cases for medical necessity must review sufficient clinical information to make the appropriate medical necessity determination." The remainder of the policy did not appear to describe the process for reviewing for medical necessity decisions, but instead focused on urgent care services coverage, emergency services coverage, and poststabilization services requirements documented in federal rule related to payment. As such, HSAG recommends that the MCO review the policy title and the purpose of the policy to ensure the intent of the policy is clear. HSAG also recommends that the policy be supported by procedures to ensure that the processes related to emergency and poststabilization services (e.g., internal authorization processes) are clearly outlined for utilization management staff awareness.		
Required Actions: None.		
Coverage and Payment of Poststabilization Care Services		
11. The MCO is financially responsible for poststabilization care services obtained within or outside the MCO that are pre-approved by a plan provider or other MCO representative. 42 CFR §438.114(e) 42 CFR §422.113(c)(2)(i) Contract F.1.10(a)(1)	**HSAG Required Evidence:** • Policies and procedures • Claims workflow • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS-302 Post Stabilization Services Policy II. C. 1. a. page 2 • IA Combined Roles and CRP Detailed Agenda – entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 – entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 – entire document • IA Provider Manual 020923 page 38 • IA Life of a Claim – entire document	☒ Met ☐ Not Met
MCO Description of Process: Prior authorization is not required for coverage of Post-Stabilization Services when these services are provided in any emergency department or for services in an observation level of care. Molina is financially responsible for post-stabilization care services obtained within or outside the MCO that are pre-approved by a plan provider of Molina representative. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
12. The MCO is financially responsible for poststabilization care services obtained within or outside the MCO that are not pre-approved by a plan provider or other MCO representative, but administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further poststabilization care services. 42 CFR §422.113(c)(2)(ii) Contract F.1.10(a)(2)	**HSAG Required Evidence:** • Policies and procedures • Claims workflow • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS-302 Post Stabilization Services Policy II. C. 1. b. page 2 • IA Combined Roles and CRP Detailed Agenda – entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 – entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 – entire document • IA Provider Manual 020923 page 38 • IA Life of a Claim – entire document	☒ Met ☐ Not Met
MCO Description of Process: Prior authorization is not required for coverage of Post-Stabilization Services when these services are provided in any emergency department or for services in an observation level of care. Staff trainings are being developed using claims adjudication procedure and Life of a Claim and UM agendas and the UM program description and UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
13. The MCO is financially responsible for poststabilization care services obtained within or outside the MCO that are not pre-approved by a plan provider or MCO representative, but administered to maintain, improve, or resolve the member's stabilized condition if: a. The MCO does not respond to a request for pre-approval within one (1) hour. b. The MCO cannot be contacted. c. The MCO representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one (1) of the criteria in 42 CFR §422.113(c)(3) is met. 42 CFR §422.113(c)(2)(iii) Contract F.1.10(b)	**HSAG Required Evidence:** • Policies and procedures • Claims workflow • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS-302 Post Stabilization Services Policy II. C. 1. a.-c page 2 • IA Combined Roles and CRP Detailed Agenda – entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 – entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 – entire document • IA Provider Manual 020923 page 38 • IA Life of a Claim – entire document	☒ Met ☐ Not Met
MCO Description of Process: If the provider is requesting post stabilization services, Molina Healthcare of Iowa will respond within 1 hour of the request. If the request meets medical necessity criteria, the request will be approved. If it does not meet medical necessity criteria, the treating physician will be given the opportunity to speak to a Molina MD to determine the appropriate level of care for the member. The provider will also be instructed that post stabilization services at an observation level of care do not require authorization. Staff trainings are being developed using claims adjudication procedure and Life of a Claim and UM agendas and the UM program description and UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
14. The MCO limits charges to members for poststabilization care services to an amount no greater than what the MCO would charge the member if he or she had obtained the services through the MCO. For purposes of cost-sharing, poststabilization care services begin upon inpatient admission. 42 CFR §422.113(c)(2)(iv) Contract F.1.12	**HSAG Required Evidence:** • Policies and procedures • Claims workflow • Staff training materials **Evidence as Submitted by the MCO:** • MHI.CLMS.03.02.01 Claims Adjudication- Emergency Services, B, page 2 • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 32 • IA_Life of a Claim – entire document • IA Provider Manual 020923 page 38 • IA CRC IP Role Specific NEO Agenda 12-5-23 – entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 – entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 422.113(c)(2)(iv) and the Iowa Health Link contract. Staff trainings are being developed using claims adjudication procedure and Life of a Claim and UM agendas and the UM program description and UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
End of the MCO's Financial Responsibility		
15. The MCO's financial responsibility for poststabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care. b. A plan physician assumes responsibility for the member's care through transfer. c. An MCO representative and the treating physician reach an agreement concerning the member's care.	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual or contract • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS-302 Post Stabilization Services Policy II. C. 2 a-d. pages 2-3	☒ Met ☐ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
d. The member is discharged. 42 CFR §422.113(c)(3) Contract F.1.13	• IA Combined Roles and CRP Detailed Agenda – entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 – entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 – entire document • IA Provider Manual 020923 pg.38	
MCO Description of Process: If the provider is requesting post stabilization services, Molina Healthcare of Iowa will respond within 1 hour of the request. If the request meets medical necessity criteria, the request will be approved. If it does not meet medical necessity criteria, the treating physician will be given the opportunity to speak to a Molina MD to determine the appropriate level of care for the member. The provider will also be instructed that post stabilization services at an observation level of care do not require authorization. Staff trainings are being developed using claims adjudication procedure and Life of a Claim and UM agendas and the UM program description and UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** Although the MCO's policy included language to support this requirement, HSAG recommends that the MCO update its provider manual to ensure providers are aware when the MCO's financial responsibility ends related to poststabilization care services.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services						
Met	=	15	X	1	=	15
Not Met	=	0	X	0	=	0
Total	=	15	Total Score		=	15
				Total Score ÷ Total	=	100%

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		

1. The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.
 	
42 CFR §438.206(b)(1)
Contract E.1.05
Contract E.1.21
	HSAG Required Evidence:
	• Policies and procedures
	• Provider materials, such as the provider manual
	• Copy of each type of provider contract template, including ancillary, hospital, and individual/group
	• Provider Network Onboarding Plan (as requested in the MCO Questionnaire)
	• Network adequacy analyses, such as GeoAccess mapping
	• Staff training materials
	
	Evidence as Submitted by the MCO:
	• MHI NSS – 2 Availability of Services and Adequate Capacity Procedure pg 1 II. (b) (1)
	• MHI NSS – 1.3 Network Accessibility & Adequacy Procedure pg 2 and 3
	• IA MW2-30 Network Provider Listing Medical Sample Provider File tab 2 “Data Feed”
	• Iowa Network Adequacy Reports by Region
	• IA Provider Manual 020923 page 16-17, 70, 141, 147
	• Confirmed copies of each contract template include:
	  o Molina Iowa HCBS (Home and Community Based Services)
	  o MolinaIowa HSA (Hospital Services Agreement)
	  o Molina Iowa PSA (Provider Services Agreement)
	• IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL, pg 1
	• Iowa Provider Services Employee Staff Training 2023 Final - Slide 75
		☐ Met
		☒ Not Met

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") has provided the following evidence for this element that includes two procedures, referenced pages within our Provider Manual, provided copies of each provider contract type requested, including the relevant portion of our Provider Network Onboarding plan that also includes Geo Access mapping. Lastly, we provided the relevant portion of our IA Provider Services Staff Training Deck to provide training content to our Provider Services team.		
HSAG Findings: Although the MCO has made progress in recruiting and contracting with providers, gaps remain for hospitals, specialty providers (i.e., pediatrics), behavioral health (i.e., pediatric/adolescent substance abuse), and Home- and Community-Based Services (HCBS)/LTSS providers. During the site review, MCO staff members described their comprehensive plan for continued development of the MCO's network and indicated they would enter into single case agreements (SCAs) as necessary. MCO staff members also explained that the MCO is close to finalizing contracts with two large healthcare systems which will close some of the identified provider gaps.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Demonstrate that significant progress has been made toward achieving an adequate network with an appropriate range of providers to serve members assigned to the MCO. • Submit network adequacy reports routinely that demonstrate progress and include, at a minimum, provider counts by provider type and a time and distance analysis once the MCO receives an enrollment file from HHS.		
2. The MCO provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist. 42 CFR §438.206(b)(2) Contract F.4.01	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Coverage/authorization guidelines • Staff training materials **Evidence as Submitted by the MCO:** • MHI NSS – 2 Availability of Services and Adequate Capacity Procedure pg 1 II. (b) (2) • IA Provider Manual 020923, Page 72 • Iowa Provider Services Employee Staff Training 2023 Final - Slide 75 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg 26	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa has provided the following evidence for this element: Availability of Services and Adequate Capacity Procedure, coverage/authorization guidelines from our Provider Manual, dedicated slide in our Staff Training Deck, and most importantly narrative/content around this element in our Member Handbook.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element. **Recommendations:** HSAG recommends that the MCO ensure that contracted obstetric providers have hospital privileges with contracted hospitals to mitigate any barriers for pregnant members in delivering their babies.		
Required Actions: None.		
3. The MCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. 42 CFR §438.206(b)(7) Contract E.1.23	**HSAG Required Evidence:** • Policies and procedures • Provider Network Onboarding Plan (as requested in the MCO Questionnaire) • Network adequacy analyses, such as GeoAccess mapping • List of provider types designated as family planning providers **Evidence as Submitted by the MCO:** • MHI NSS – 2 Availability of Services and Adequate Capacity Procedure pg 1 II. (b) (7) • IA MW2-30 Network Provider Listing Medical Sample Provider File tab 2 "Data Feed" *Search "Family Planning" and see examples: rows 679, 833, etc.* • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL pg 1 • Iowa Provider Services Employee Staff Training 2023 Final - Slide 76 • Iowa – for Standard IV Availability of Services Family Planning Provider Types	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa has provided the following evidence for this element that includes our procedures, our Provider Network Onboarding plan that also includes Geo Access mapping. We have also included the element in our staff training deck for our provider services team. Lastly, we provided a list of family planning providers via provider type 22 that we are currently recruiting to become in-network providers by location.		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: Although the MCO has made progress in recruiting and contracting with providers, sufficient evidence was not provided to demonstrate the MCO has an adequate network of family planning providers. During the site review, MCO staff members described their comprehensive plan for continued development of the MCO's network and indicated they would enter into SCAs as necessary. MCO staff members also explained that the MCO is close to finalizing contracts with two large healthcare systems which will close some of the identified provider gaps.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Demonstrate that significant progress has been made toward achieving an adequate network with an appropriate range of providers to serve members assigned to the MCO. • Submit network adequacy reports routinely that demonstrate progress and include, at a minimum, provider counts by provider type and a time and distance analysis once the MCO receives an enrollment file from HHS.		
4. The MCO provides for a second opinion from a network provider or arranges for the member to obtain one outside the network, at no cost to the member. 42 CFR §438.206(b)(3) Contract F.4.02	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Coverage/authorization guidelines • Staff training materials **Evidence as Submitted by the MCO:** • MHI NSS – 2 Availability of Services and Adequate Capacity Procedure pg 1 II. (b) (3) • IA HCS-390.01 Second Opinions Procedure_IA RR • Iowa Provider Services Employee Staff Training 2023 Final - Slide 76 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg 29 and 66	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has provided the following evidence for this element that includes a Procedure for second opinions to facilitate member and/or practitioner requests in obtaining a second opinion, our Availability of Services Procedure, and also included the element in our staff training deck for our provider services team. Lastly, the narrative/content around this element is highlighted in our Member Handbook.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
5. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCO adequately and timely covers these services out of network for the member, for as long as the MCO provider network is unable to provide them. 42 CFR §438.206(b)(4) Contract F.4.03	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Network adequacy monitoring mechanisms • Coverage/authorization guidelines • Provider Network Onboarding Plan (as requested in the MCO Questionnaire), including provider network contingency plan • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS 2a Availability of Services Adequate Capacity State Addendum Pg1 • IA HCS-391.01 Non-Participating Provider PA Requests Procedure_IA RR • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL pg 11 • Iowa Provider Services Employee Staff Training 2023 Final - Slide 77 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg 89	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has provided the following evidence for this element that includes a procedure for Molina Healthcare of Iowa Services (HCS) staff to review elective prior authorization requests for Non-Participating Providers, including our Availability of Services State Addendum and Provider Network Onboarding Plan. Lastly, we included the staff training deck for our provider services team as well as content for this element in our Member Handbook.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
6. *The MCO negotiates and executes written single case agreements or arrangements within non-network providers, when necessary, to ensure access to covered services.*	**HSAG Required Evidence:** • Policies and procedures • Out-of-network contracting workflow • Single case agreement template	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Contract F.4.04	• Provider Network Onboarding Plan (as requested in the MCO Questionnaire), including provider network contingency plan • Staff training materials **Evidence as Submitted by the MCO:** • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL pg 11 • MHIA SCA template • IA SOP Single Case Agreement Final pg 1 • Iowa Provider Services Employee Staff Training 2023 Final - Slide 77	
MCO Description of Process: Molina Healthcare of Iowa has provided the following evidence for this element that includes SCA content and a contingency plan within our Provider Network Onboarding Plan. In addition, we have also provided our MHIA Single Case Agreement template to be used with Non-Network providers as well as our Standard Operating Procedure (SOP) outlining the contracting workflow to be used as a training mechanism coupled with training content within our Staff Training deck for our provider services team.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
7. The MCO requires out-of-network providers to coordinate with the MCO for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network. 42 CFR §438.206(b)(5) Contract F.4.06	**HSAG Required Evidence:** • Policies and procedures • Claims processing guidelines • Provider materials, such as materials on the MCO's website (e.g., provider manual) • Single case agreement template • Staff training materials **Evidence as Submitted by the MCO:** • MHI NSS – 2 Availability of Services and Adequate Capacity Procedure - Medicaid pg 2 (#5) • IA Provider Manual 020923 pg 53, and pg 147 • MHIA SCA – entire document	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• IA SOP Single Case Agreement Final pg 2 • Iowa Provider Services Employee Staff Training 2023 Final - Slide 77	
MCO Description of Process: Molina Healthcare of Iowa has provided the following evidence for this element that we include in our SCA Standing Operation Procedure content. In addition, we have also have this requirement within our Availability of Services Procedure and Provider Manual. All documents will be used as part of training materials as well as outlined within our Staff Training deck for our provider services team.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
8. *With the exception of single case agreements and other arrangements established with out-of-network providers, the MCO pays out-of-network providers no less than eighty (80) percent of the rate of reimbursement to in-network providers.* Contract F.4.07	**HSAG Required Evidence:** • Policies and procedures • Claims processing and payment guidelines • Out of network fee schedule documentation • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS 2a Availability of Services Adequate Capacity State Addendum pg 3 • 9-B MHI.CLMS.03.02 Claims Adjudication Procedure 021323 – pg. 2 and 5 • IA Provider Manual 020923 – Pg. 111 • Iowa Provider Services Employee Staff Training 2023 Final - Slide 78	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has embedded this requirement within our Provider Manual. Documents will be used as part of training materials as well as outlined within our Staff Training deck for our provider services team. Molina will configure our claims processing system to pay out of network providers at no less than eighty (80) percent of the Medicaid fee schedule in effect at the time of service, following the payment guidelines of our claims adjudication procedure and as documented in our Availability of Services Adequate Capacity State Addendum fee schedule.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
9. *The MCO ensures that no provider bills a member for all or any part of the cost of a treatment service, except as allowed for Title XIX cost sharing and Client Participation as described in Section F.8 of the contract.* Contract F.4.08	**HSAG Required Evidence:** • Policies and procedures • Provider contract template • Provider materials, such as the provider manual • Plan for provider monitoring of balance billing practices • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS 2a Availability of Services Adequate Capacity State Addendum pg 3 • Molina Iowa PSA pg 9 Section 4.3 and 4.4 • IA Provider Manual 020923 pg 11 • Iowa Provider Services Employee Staff Training 2023 Final - Slide slide 54 and 77 • Iowa SOP - BalanceBilling	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has provided our IA MHI NSS Availability of Services State Addendum to ensure this requirement will be carried through, we have also established this requirement within our Provider Contract Templates that providers sign when coming in network with our health plan as well as our Provider Manual. In addition, we have developed a SOP outlining how we monitor balance billing practices. Finally, we will be using all documents including our Staff Training Deck for training materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
10. *The MCO uses processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.* Contract F.4.09	**HSAG Required Evidence:** • Policies and procedures • Plan for parity for mental health and substance use disorder benefits • Coverage/authorization guidelines • Staff training materials **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Contract F.13.09	• HCS-609 BH Mental Health Parity and Addictions Equity Policy_IA RR – Entire document • HCS-609.01 BH Mental Health Parity and Addictions Equity Procedure_IA RR – Entire document • BH 420 Mental Health Parity Overview • 03 MHPAEA QRG • Iowa Provider Services Employee Staff Training 2023 Final – Slide 79	
MCO Description of Process: Molina Healthcare of Iowa has provided our BH Mental Health Parity and Addictions Equity policy and procedure, coupled with Mental Health Parity and Addiction Equity Act training deck by our Behavioral Health Integration Team. Lastly, we have provided our Mental Health Parity Quick Reference Guide describing coverage and authorizations.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
42 CFR §438.206(b)(6) requires the MCO to demonstrate that its network providers are credentialed as required by §438.214. This requirement is reviewed under Standard VIII: Provider Selection.		
Timely Access		
11. The MCO meets and requires its network providers to meet HHS standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Access Standards: Appointment Times Checklist. 42 CFR §438.206(c)(1)(i) Contract E.5.01(a) Contract Exhibit C: General Access Standards	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Plan to monitor compliance with appointment time standards (e.g., surveys (submit contract, if survey to be conducted by a delegate), time frame/schedule, notice of results template to providers, corrective action plan [CAP] process, etc.) • Staff training materials • HSAG will also use the results of the Access Standards: Appointment Times Checklist **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network pgs. 1-3 • IA Provider Manual 020923 pg 71-72 • IA C-01.7_Prompt Response to Compliance Issues Procedure Entire document • Iowa Provider Services Employee Staff Training 2023 Final - slide 46-47 • IA_Provider Availability Survey Entire document • IA_Member Satisfaction Overall Analysis Procedure page 1	
MCO Description of Process: Molina Healthcare of Iowa has embedded all General Access Standards according to our contract within our Network Accessibility and Adequacy State Addendum, in addition to our Provider Manual, Provider Orientation, and Staff Training Deck. Molina uses the Provider Availability Survey and Member Satisfaction Overall Analysis Procedure to monitor compliance with required appointment time standards. We have also provided our corporate Prompt Response to Compliance Issues overarching policy and procedure out lining our internal and external corrective action plans.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
12. The MCO ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid members. 42 CFR §438.206(c)(1)(ii) Contract E.5.01(b)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Plan for provider monitoring of hours of operation • Staff training materials **Evidence as Submitted by the MCO:** • MHI NSS – 2 Availability of Services and Adequate Capacity Procedure - Medicaid pg 2 • IA Provider Manual 020923 pg 70, 73 • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL pg 6 • Iowa Provider Services Employee Staff Training 2023 Final - Slide 80	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa has this requirement outlined within our MHI NSS 2 Availability of Service procedure, our Provider Services Agreement provider templates, a Plan for Monitoring is within our Provider Manual including our Provider Network Onboarding Plan. These documents as well as our Staff Training Deck will be used for staff training materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
13. The MCO makes services included in the contract available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. 42 CFR §438.206(c)(1)(iii) Contract E.1.01(a) Contract E.5.01(c)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Plan for provider monitoring of service availability • Staff training materials **Evidence as Submitted by the MCO:** • MHI NSS – 2 Availability of Services and Adequate Capacity Procedure – Medicaid pg 2 • Molina Iowa PSA pg 5 Section 2.1 Provider Standards • IA Provider Manual 020923 pg 70, 72 and 73 • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL pg 6 • Iowa Provider Services Employee Staff Training 2023 Final - Slide 80	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has this requirement outlined within our Provider Services Agreement provider templates. A Plan for monitoring service availability is noted within our Provider Manual and included our Provider Network Onboarding Plan. These documents as well as our Staff Training Deck will be used for staff training materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
14. The MCO establishes mechanisms to ensure compliance with timely access to care and services standards by network providers. a. The MCO monitors network providers regularly to determine compliance b. The MCO takes corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(iv-vi) Contract E.1.22 Contract E.5.01(d-f)	**HSAG Required Evidence:** • Policies and procedures • Plan to monitor compliance with appointment time standards (e.g., surveys [submit contract, if survey to be conducted by a delegate], time frame/schedule, notice of results template to providers, CAP process, etc.) • CAP template • Staff training materials **Evidence as Submitted by the MCO:** • MHI NSS - 2 Availability of Services and Adequate Capacity Procedure - Medicaid signed – pg. 2 Section II. C. 1 • Molina Iowa PSA pg 8 section 3.7 • IA Provider Manual 020923 pg 73, 77 • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL pg 6 and 9 • IA_Corrective Action Plan letter_template Entire document • Iowa Provider Services Employee Staff Training 2023 Final - Slide 81	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has this requirement outlined within our Provider Services Agreement provider templates. The Plan for Monitoring is highlighted within our Provider Manual and our Provider Network Onboarding Plan. These documents as well as our Staff Training Deck will be used for staff training materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
15. *The MCO maintains an emergency/contingency plan in the event that a large provider of services collapses or is otherwise unable to provide needed services.* Contract E.1.22	**HSAG Required Evidence:** • Policies, procedures, and workflows • Emergency/contingency plan template that identifies alternative providers • Staff training materials **Evidence as Submitted by the MCO:** • IA_ HCS-407.01 – entire policy, especially pg 4 section D.1.b and E.4 • IA SOP Network Emergency Contingency Plan pg 3 • Iowa Provider Services Employee Staff Training 2023 Final - Slide 81	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has provided our Network Emergency Contingency Plan outlining policies and procedures around Provider terminations (whether initiated or with cause), member notifications, agency notifications, including significant terminations and end to end accountability. This SOP will be used as staff training materials including a slide in our staff training deck for our provider services team. Molina will utilize our IA SOP Network Emergency Contingency Plan to submit to HHS for an approved implement mechanism to regularly monitor Providers to ensure compliance.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Access and Cultural Considerations		
16. The MCO participates in HHS' efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, *sexual orientation, or gender identity.* 42 CFR §438.206(c)(2) Contract G.6.01	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Cultural competency plan • Cultural competency training plan • Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• Provider Network Onboarding Plan (as requested in the MCO Questionnaire) • Staff training materials	
	Evidence as Submitted by the MCO: • IA Provider Manual 020923 – page 16-17, 19 • Molina Iowa PSA pg 2 (i) • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL – page 1 • Iowa Provider Services Employee Staff Training 2023 Final - Slides 44 and 82; • IA POD Data Elements excel spreadsheet • IA_ Pract Ntwk Cult Responsiveness Draft Procedure – entire document • IA_Cultural Competency Training Plan – entire document • Person Centered Care – Care Plan and Cultural Competency PPT – entire document • Introduction to Cultural Competency Module 1-2022 – entire document • Cultural Competency Module 2 2022 – entire document	
MCO Description of Process: Molina Healthcare of Iowa has incorporated cultural competency information and trainings within our Provider Manual, our Provider Services Agreement provider templates, we also incorporated into our Provider Network Onboarding Plan including our Staff Training Deck and Provider Orientation. Lastly, our Staff is required to complete our Cultural Company course as soon as they are brought on board. Any provider and/or individual has access at any time to 5 Cultural Competency Modules located on each of our existing health plans public websites including but not limited to CC, Health Disparities, and Special Population Focuses. In addition, we also attached the Provider Directory Data Elements for examples of provider profiles that include cultural competency, please reference 1st tab, row 10 as evidence.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
17. *The MCO addresses the special health needs of members who are poor, homeless and/or members of a minority population group. The MCO incorporates in its policies, administration, and service practices, and communicates them to providers and subcontractors, the values of:* a. *Honoring members' beliefs.* b. *Sensitivity to cultural diversity.* c. *Fostering in staff and providers' attitudes and interpersonal communication styles which respect members' cultural backgrounds.* Contract G.6.02	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Subcontractor materials, such as the subcontractor contract • Cultural competency plan • Cultural competency training plan • Staff training materials **Evidence as Submitted by the MCO:** • IA Provider Manual 020923 – page 16 • Molina Iowa PSA pg2 (i) • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL – page 1 • Iowa Provider Services Employee Staff Training 2023 Final - Slides 44 and 82 • Introduction to Cultural Competency Module 1-2022 – entire document • Cultural Competency Module 2 2022 – entire document • Person Centered Care – Care Plan and Cultural Competency PPT – entire document • IA_Cultural Competency Training Plan – entire document • IA_Quality Program Management Draft Procedure, Page 16 (4.c)	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has incorporated cultural competency information and trainings within our Provider Manual, our Provider Services Agreement provider templates, we also incorporated into our Provider Network Onboarding Plan including our Staff Training Deck and Provider Orientation. Lastly, our Staff is required to complete our Cultural Company course as soon as they are brought on board. Any provider and/or individual has access at any time to 5 Cultural Competency Modules located on each of our existing health plans public websites including but not limited to CC, Health Disparities, and Special Population Focuses.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Accessibility Considerations		
18. The MCO ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3) Contract E.5.02	**HSAG Required Evidence:** • Policies and procedures • Provider materials such as the provider manual and provider contract • Mechanism to assess network providers' accessibility • Example(s) of provider profiles (i.e., accessibility accommodations [e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment]) on provider directory • Provider Network Onboarding Plan (as requested in the MCO Questionnaire) • Staff training materials **Evidence as Submitted by the MCO:** • IA Provider Manual 020923 pg 18 and 74 • P&P – MHI NSS 1.3 Network Accessibility and Adequacy Procedure pg 2 • MHI NSS - 2 Availability of Services and Adequate Capacity Procedure - Medicaid signed – Page 2 Section II.c.3 • IA_Tracking and Trending Member Complaints – pg 4-5 section II.o-s • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL pg 1 • IA POD Data Elements Excel spreadsheet • Iowa Provider Services Employee Staff Training 2023 Final – Slide 83	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has this element embedded within our Provider Manual, Provider Network Onboarding Plan, as well as our MHI NSS Network Accessibility and Adequacy Procedure. In addition, we also attached the Provider Directory Data Elements for examples of		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
provider profiles, please reference both tabs. The data elements in the IA POD Data Elements excel spreadsheet will display in a user friendly, searchable provider online directory.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. Please refer to Standard II, Element 17 for additional recommendations.		
Required Actions: None.		

Standard IV—Availability of Services						
Met	=	16	X	1	=	16
Not Met	=	2	X	0	=	0
Total	=	18	**Total Score**		=	16
				Total Score ÷ Total	=	89%

Standard IV—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
Primary Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) Contract Exhibit C: General Access Standards	1. *Primary care provider (PCP) appointments are available as follows:* *a. Routine: not to exceed four (4) to six (6) weeks from the date of a member's request;* *b. Persistent symptoms: within forty-eight (48) hours; and* *c. Urgent: within one (1) day.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA Provider Manual 020923 pg 72 • Iowa Provider Services Employee Staff Training 2023 Final slide 42 • Iowa Provider Orientation - DRAFT 2023 with Narrative slide 56	
Specialty Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) Contract Exhibit C: General Access Standards	2. *For specialty referrals to specialty physicians and other diagnostic and treatment healthcare providers, the MCO provides appointments in accordance with the following*: a. *Routine: not to exceed thirty (30) days; and* b. *Urgent: not to exceed one (1) day.* **Evidence as submitted by the MCO:** • IA Provider Manual 020923 pg 72 • Iowa Provider Services Employee Staff Training 2023 Final slide 42 • Iowa Provider Orientation - DRAFT 2023 with Narrative slide 56	Y ☒ N ☐
Behavioral Health Access Standards		
42 CFR §438.206(c)(1)(i) Contract Exhibit C: General Access Standards	3. *For behavioral health providers, the MCO provides appointments in accordance with the following*: a. *Emergency: upon presentation at a service delivery site;* b. *Mobile crisis: within one (1) hour of presentation or request;* c. *Urgent: within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with the provider or MCO;* d. *Persistent symptoms: within forty-eight (48) hours of reporting symptoms;* e. *Routine: within three (3) weeks of the request;* f. *Substance use disorder and pregnancy: within forty-right (48) hours of seeking treatment; and*	Y ☒ N ☐

Standard IV—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
	g. *Intravenous drug use: admitted not later than fourteen (14) days after making the request for admission, or one hundred and twenty (120) days after the date of such request if no program has the capacity to admit the member on the date of such request and if interim services are made available to the member not later than forty-eight (48) hours after the request.*	
	Evidence as submitted by the MCO: • IA Provider Manual 020923 pg 72 and 73 • Iowa Provider Services Employee Staff Training 2023 Final slide 43 • Iowa Provider Orientation - DRAFT 2023 with Narrative slide 57	
General Optometry Services Access Standards		
42 CFR §438.206(c)(1)(i) Contract Exhibit C: General Access Standards	4. *For general optometry services, the MCO provides appointments in accordance with the following*: a. *Routine: not to exceed three (3) weeks; and* b. *Urgent: not to exceed forty-eight (48) hours.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA Provider Manual 020923 pg 72 • Iowa Provider Services Employee Staff Training 2023 Final slide 42 • Iowa Provider Orientation - DRAFT 2023 with Narrative slide 56	
Laboratory and X-Ray Services Access Standards		
42 CFR §438.206(c)(1)(i) Contract Exhibit C: General Access Standards	5. *For laboratory and x-ray services, the MCO provides appointments in accordance with the following*: a. *Routine: not to exceed three (3) weeks; and* b. *Urgent: not to exceed forty-eight (48) hours.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA Provider Manual 020923 pg 72 • Iowa Provider Services Employee Staff Training 2023 Final slide 42 • Iowa Provider Orientation - DRAFT 2023 with Narrative slide 56	

Standard IV—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
Hospital and Emergency Services Access Standards		
42 CFR §438.206(c)(1)(i) Contract Exhibit C: General Access Standards	6. *All emergency care is immediate, at the nearest facility available, regardless of whether the facility or provider is contracted with the MCO.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA Provider Manual 020923 pg 72 • Iowa Provider Services Employee Staff Training 2023 Final slide 42 • Iowa Provider Orientation - DRAFT 2023 with Narrative slide 56	

Standard V—Assurances and Adequate Capacity of Services		
Requirement	**Supporting Documentation**	**Score**
Basic Rule		
1. The MCO gives assurances to HHS and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with HHS' standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). a. The MCO submits documentation to HHS, *as required by the Reporting Manual*, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. iii. *Ensures that the services can be furnished promptly and without compromising the quality of care.* b. *Demonstrates sufficient access to essential hospital services to serve the expected enrollment.* 42 CFR §438.207(a); (b)(1-2) Contract E.1.01(b) Contract E.1.11 Contract E.1.24 Contract E.1.26-E.1.27 Contract Exhibit C: General Access Standards	**HSAG Required Evidence:** • Policies and procedures • Provider Network Onboarding Plan (as requested via the Questionnaire) • Plan for network adequacy monitoring • Network adequacy reports/analyses (i.e., provider network and performance target reports, including the projected number of providers required for each provider type and contracting status) • Staff training materials • HSAG will also use the results of the Access Standards: Time/Distance Checklist **Evidence as Submitted by the MCO:** • MHI NSS 1.3 Network Accessibility and Adequacy Procedure – Medicaid.docx - pgs 1-4 • IA 2022 MHI NSS 1.3a Network Accessibility & Adequacy State Addendum – Provider Network.docx - pgs 1-3 • MW2-30 Network Provider Listing Medical Sample Provider File.xlsx Tab 2 Data Feed and Rural vs Urban tab • Iowa Network Adequacy Reports by Region – entire document • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL.docx - Pg 2 and 8-9 • Iowa Provider Services Employee Staff Training 2023 Final.pptx -slide 84	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") has outlined this element within our Network Accessibility and Adequacy Procedure as well as State Addendum. We've also supplied our Network Provider Listing Sample excel spreadsheet by provider type, time		

Standard V—Assurances and Adequate Capacity of Services		
Requirement	**Supporting Documentation**	**Score**
and distance, rural vs urban. We have also outlined this in our Provider Network Onboarding Plan. These documents including content in our Staff Training Deck will be used for training purposes.		
HSAG Findings: Although the MCO had made progress in recruiting and contracting with providers, gaps remain for hospitals, specialty providers (i.e., pediatrics), behavioral health (i.e., pediatric/adolescent substance abuse), and HCBS/LTSS providers. During the site review, MCO staff members described their comprehensive plan for continued development of the MCO's network and indicated they would enter into SCAs as necessary. MCO staff members also explained that the MCO is close to finalizing contracts with two large healthcare systems which will close some of the identified provider gaps.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Demonstrate that significant progress has been made toward achieving an adequate network with an appropriate range of providers to serve members assigned to the MCO. • Submit network adequacy reports routinely that include, at a minimum, provider counts by provider type and a time and distance analysis once the MCO receives an enrollment file from HHS.		
Timing		
2. The MCO submits the documentation in 42 CFR §438.207(b) as specified by HHS, but no less frequently than the following: a. At the time it enters into a contract with HHS. b. On an annual basis. c. At any time there has been a significant change (as defined by HHS) in the MCO's operations that would affect the adequacy of capacity in services, including: i. Changes in MCO services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the MCO. "Significant change" is defined as a change in the MCO's operations or the program, changes in services, changes in benefits, changes in payments, enrollment of a new population, or as otherwise requested by HHS. 42 CFR §438.207(c) Contract E.1.28 Contract E.1.32	**HSAG Required Evidence:** • Policies and procedures • Provider Network Onboarding Plan (as requested via the Questionnaire) • Network adequacy reports/analyses (i.e., provider network and performance target reports, including the projected number of providers required for each provider type and contracting status) • Calendar of deliverables to comply with Reporting Manual • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS 2a Availability of Services & Adequate Capacity State Addendum – Provider Network.docx - pg 2 • MW2-30 Network Provider Listing Medical Sample Provider File.xlsx Tab 2 Data Feed and Urban vs Rural tab • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL.docx - pg 6	☒ Met ☐ Not Met

Standard V—Assurances and Adequate Capacity of Services		
Requirement	**Supporting Documentation**	**Score**
	• Iowa Provider Services Employee Staff Training 2023 Final.pptx – slide 85 • IA_Network Provider Reporting Calendar.xlsx	
MCO Description of Process: Molina Healthcare of Iowa has outlined this element within our Network Accessibility and Adequacy State Addendum. We've also supplied our Network Provider Listing Sample excel spreadsheet by provider type, time and distance, rural vs urban. We have also outlined this in our Provider Network Onboarding Plan. These documents including content in our Staff Training Deck will be used for training purposes.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
State Requirements		
3. *The MCO ensures compliance with 42 CFR §441.22 by including nurse practitioners in its provider network and making nurse practitioner services available to members.* Contract E.1.09	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports/analyses • Provider Network Onboarding Plan (as requested via the Questionnaire) • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS 1.3a Network Accessibility & Adequacy State Addendum – Provider Network.docx - pg 4 • IA_Cred-Recred Practitioner Procedure.docx - Pg 7 and 8 • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL.docx - pg 1 • Iowa Provider Services Employee Staff Training 2023 Final.pptx -slide 86	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has included this element in our Network Accessibility & Adequacy State Addendum and Provider Network onboarding plan. We have also provided our Credentialing and Recredentialing practitioners procedure. These documents will be used as training modules for staff training including the staff training slide deck for provider services.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		

Standard V—Assurances and Adequate Capacity of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
4. *The MCO administers and funds the State's Health Home services within the approved Integrated Health Home State Plan Amendment.* a. *The MCO provides oversight that includes, but is not limited to, documentation reviews and provider self-assessment reviews to ensure that health home providers are meeting all of the requirements of the Health Home State Plan Amendments, Health Home Manual, and Administrative Rules.* b. *The MCO provides guidance to health home providers to ensure the requirements of the Health Home State Plan Amendments, Health Home Manual, and Administrative Rules are being met.* c. *The MCO is responsible for any identified deficiencies.* d. *In accordance with federal requirements, the MCO ensures non-duplication of payment for similar services that are offered through another method, such as 1915(c) HCBS waivers, other forms of community-based case management, or value-based purchasing arrangements.* Contract E.1.13	**HSAG Required Evidence:** • Policies and procedures • One example of a health home contract • Implementation/communication plan for working with the health homes • Oversight and monitoring plan for health homes • Provider Network Onboarding Plan (as requested via the Questionnaire) • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network.docx - pg 4 • Molina Iowa HCBS PSA (FFS) contract template – entire document • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL - pg 1 • Iowa Provider Services Employee Staff Training 2023 Final - slide 87 • IA_IHH_Policy_20230202 – entire document • IA_IHH Procedure_20230202 – pg. 2 Section II.D. • IA IHH_101 Provider Facing.pptx – entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has provided an example of a Health Home contract which is utilized by our Provider Services Agreement Contract Template. We have also incorporated this element within our Network Accessibility and Adequacy State Addendum to further amplify health homes. In addition, we have also included this provider type within our Provider Network Onboarding Plan. Furthermore, we've developed IHH P&P's detailing monitoring and oversight IHH's. All documents will be used for staff training purposes including our Staff Training Deck for Provider Services.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		

Standard V—Assurances and Adequate Capacity of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
5. *The MCO offers to contract with all federally qualified health centers (FQHCs) and rural health clinics (RHCs) located in Iowa.* a. *The MCO may establish quality standards that FQHCs and RHCs must meet to be offered network participation.* b. *The MCO reimburses all FQHCs and RHCs the Prospective Payment System (PPS) rate in effect on the date of service for each encounter.* c. *The MCO does not enter into alternative reimbursement arrangements without prior approval from HHS.* Contract E.1.14	**HSAG Required Evidence:** • Policies and procedures • One example of a FQHC and one example of a RHC contract • Quality standards FQHCs and RHCs must meet to be offered network participation, if applicable (if the MCO has not set any quality standards, state so in the MCO Description of Process) • Alternative reimbursement arrangement, if applicable (if the MCO has not entered into alternative reimbursement arrangement, state so in the MCO Description of Process) • Network adequacy reports/analyses • Provider Network Onboarding Plan (as requested via the Questionnaire) • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network.docx - pg 5 • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL.docx - pg1 • MW2-30 Network Provider Listing Medical Sample Provider File.xlsx Tab 2 Data Feed and Urban vs Rural tab • Iowa Network Adequacy Reports by Region • Iowa Provider Services Employee Staff Training 2023 Final.pptx - slide 88 • Molina Iowa PSA (FFS) – FQHC • Molina Iowa PSA (FFS) - RHC	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa offers contracts with all FQHC's and RHC's. We have provided our contract template for both (FQHC and RHC). We are currently in contract discussions with several (if not all) FQHC's and RHC's statewide. We currently have not set any quality		

Standard V—Assurances and Adequate Capacity of Services		
Requirement	**Supporting Documentation**	**Score**
standards at this time nor have we entered into alternative reimbursement arrangements. All documents will be used for staff training purposes including our Staff Training Deck for Provider Services.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
6. *The MCO makes a reasonable and good faith attempt to contract with all local family planning clinics that are enrolled as such with Iowa Medicaid.* Contract E.1.15	**HSAG Required Evidence:** • Policies and procedures • One example of a family planning contract • Network adequacy reports/analyses • Documentation of outreach to family planning clinics • Provider Network Onboarding Plan (as requested via the Questionnaire) • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS – 2a Availability of Services and Adequate Capacity State Addendum– pg 2 • MW2-30 Network Provider Listing Medical Sample Provider File.xlsx - Tab 2 Data Feed and Urban vs Rural tab • Molina Iowa PSA (FFS) - Contract Template • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL.docx - pg 1 • Family Planning email.msg – Planned Parenthood outreach • Iowa Provider Services Employee Staff Training 2023 Final.pptx - slide 89	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has incorporated this element into our Availability of Services and Adequate Capacity State Addendum, we have also incorporated it into our Network adequacy reports/analyses. We have provided our Provider Services Agreement contract template for family planning providers as well as included this provider type within our Provider Network Onboarding Plan. Lastly, we have submitted an email exchange with Planned Parenthood as evidence of outreach. All documents will be used for staff training purposes including our Staff Training Deck for Provider Services.		

Standard V—Assurances and Adequate Capacity of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
7. *The MCO makes a reasonable and good faith attempt to contract with all maternal and child health centers funded by Title V moneys.* Contract E.1.16	**HSAG Required Evidence:** • Policies and procedures • One example of a maternal and child health center contract • Network adequacy reports/analyses • Documentation of outreach to maternal and child health centers • Provider Network Onboarding Plan (as requested via the Questionnaire) • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network.docx - pg 6 • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL.docx - pg 1 • MW2-30 Network Provider Listing Medical Sample Provider File.xlsx - Tab 2 Data Feed and Urban vs Rural tab • Iowa Provider Services Employee Staff Training 2023 Final.pptx - slide 89 • Molina of Iowa and Un of Iowa_Signed by UI 2.1.23.pdf – MCHC contract • Molina of Iowa and Univ of Iowa Clean w DSA.pdf – entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has incorporated this element into our Network Accessibility and Adequacy State Addendum, we have also incorporated it into our Network adequacy reports/analyses. We have provided our Provider Services Agreement contract template for maternal and child health center providers as well as included this provider type within our Provider Network Onboarding Plan. Lastly, Title V Child Health Specialty		

Standard V—Assurances and Adequate Capacity of Services		
Requirement	**Supporting Documentation**	**Score**
Clinics (CHSC) is part of University of Iowa Healthcare and do have a signed agreement in-house. All documents will be used for staff training purposes including our Staff Training Deck for Provider Services.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
8. *The MCO has strategies, policies, and procedures describing how it utilizes urgent care clinics in the delivery of care to members, and documents such in the Policies and Procedures Manual (PPM).* Contract E.1.17	**HSAG Required Evidence:** • Policies and procedures • Member materials • Provider Network Onboarding Plan (as requested via the Questionnaire) • Staff training materials **Evidence as Submitted by the MCO:** • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL.docx - pg 1 • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network.docx - pg 8 • Iowa Provider Services Employee Staff Training 2023 Final.pptx - slide 90 • IA POD Data Elements - confirmed option for Urgent Care – Tab 2 Rows 386 and 387 • Iowa SOP - UrgentCare.docx – Entire document • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023.docx – Page 32	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa utilizes urgent care clinics in our delivery of care to members and have incorporated this within our Network Accessibility and Adequacy State Addendum as well as our Urgent Care Standard Operating Procedure (SOP) as well as our Provider Network Onboarding Plan. Urgent Care Clinics are also easily searchable via our Provider Online Directory. The State addendum and the SOP documents will be used for staff training purposes including our Staff Training Deck for Provider Services.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard V—Assurances and Adequate Capacity of Services		
Requirement	**Supporting Documentation**	**Score**
9. *The MCO has strategies, policies, and procedures describing how it utilizes and partners with community entities and advocates, and documents such in the PPM.* Contract E.1.18	**HSAG Required Evidence:** • Policies and procedures • Community engagement strategies • Community partners resource list • Staff training materials **Evidence as Submitted by the MCO:** • IA-CE.01 Community Events, Partners and Other Safety Net Providers Utilization Policy – entire document • IA-CE.01.01 Community Events, Partners and Other Safety Net Providers Utilization Procedure – entire document • IA SOP – Community and Member Advocate Engagement Final.docx – entire document • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network.docx - pg 9 • Molina Healthcare of Iowa Community Resource List Screenshot.docx • Iowa Provider Services Employee Staff Training 2023 Final.pptx - slide 90	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has incorporated partnering with community entities and advocates within our Network Accessibility and Adequacy State Addendum as well as our Member Advocate Engagement Standard Operating Procedure (SOP). Our community engagement strategies can be found in our IA-CE.01 Community Events, Partners and Other Safety Net Providers Utilization Policy and CE.01.01.01 Community Events, Partners and Other Safety Net Providers Utilization Procedure coupled with a listing of community partners resource list. The State addendum and the SOP documents will be used for staff training purposes including our Staff Training Deck for Provider Services.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard V—Assurances and Adequate Capacity of Services						
Met	=	8	X	1	=	8
Not Met	=	1	X	0	=	0
Total	=	9	Total Score		=	8
				Total Score ÷ Total	=	89%

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Primary Care Physician Access Standards		
42 CFR §438.207(a);(b)(1-2) Contract E.5.06 Contract Exhibit C: General Access Standards	1. *Within thirty (30) minutes or thirty (30) miles, to include* a. *Adult primary care providers (PCPs); and* b. *Pediatric PCPs.* **Evidence as submitted by the MCO:** • IA MCO RR Questionaire 10. Provider Network Onboarding Plan FINAL - pg 6 • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network pg 1 Section II. A.a	Y ☒ N ☐
Specialty Access Standards		
42 CFR §438.207(a);(b)(1-2) Contract E.1.12 Contract Exhibit C: General Access Standards	2. *Sixty (60) minutes or sixty (60) miles for seventy-five (75) percent of members, and ninety (90) minutes or ninety (90) miles for all members. Specialties must include:* a. *Allergy;* b. *Cardiology;* c. *Dermatology;* d. *Endocrinology;* e. *Gastroenterology;* f. *General surgery;* g. *Neonatology;* h. *Nephrology;* i. *Neurology;* j. *Neurosurgery;* k. *Obstetrics and gynecology;* l. *Occupational therapy;* m. *Oncology/hematology;* n. *Ophthalmology;* o. *Orthopedics;*	Y ☒ N ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	p. *Otolaryngology;* q. *Pathology;* r. *Physical therapy;* s. *Pulmonology;* t. *Psychiatry;* u. *Radiology;* v. *Reconstructive surgery;* w. *Rheumatology;* x. *Speech therapy;* y. *Urology;* z. *Pediatric specialties; and* aa. *Any additional specialty provider types based on the clinical needs of the membership.*	
	Evidence as submitted by the MCO: • IA MCO RR Questionaire 10. Provider Network Onboarding Plan FINAL - Top of page 7 • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network pg 1 section II.B	
Hospital Access Standards		
42 CFR §438.207(a);(b)(1-2) Contract E.1.11 Contract Exhibit C: General Access Standards	3. *Transport time is thirty (30) minutes or thirty (30) miles, except in rural areas where access time may be greater. If greater, the standard is the community standard for accessing care, and exceptions must be justified and documented to HHS on the basis of community standards.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA MCO RR Questionaire 10. Provider Network Onboarding Plan FINAL - pg 7 • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network pg 2 section II.C.a	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Long-Term Care Services Access Standards		
42 CFR §438.207(a);(b)(1-2) Contract Exhibit C: General Access Standards	4. *Usual and customary, not to exceed:* a. *Urban: thirty (30) minutes or thirty (30) miles; and* b. *Rural: sixty (60) minutes or sixty (60) miles, except where community standards and documentation shall apply.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA MCO RR Questionaire 10. Provider Network Onboarding Plan FINAL - pg 7 • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network pg 2 section II.D.b	
Behavioral Health Access Standards		
42 CFR §438.207(a);(b)(1-2) Contract E.1.10 Contract Exhibit C: General Access Standards	5. *For adult and pediatric behavioral health specialists, including mental health and substance use disorder specialists, not to exceed:* a. *Outpatient: thirty (30) minutes or thirty (30) miles, except where community standards and documentation shall apply; and* b. *Inpatient:* i. *Urban: sixty (60) minutes or sixty (60) miles.* ii. *Rural: ninety (90) minutes or ninety (90) miles.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA MCO RR Questionaire 10. Provider Network Onboarding Plan FINAL - pages 7 and 8 • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network pg 2 section II.F.a	
General Optometry Access Standards		
42 CFR §438.207(a);(b)(1-2) Contract Exhibit C: General Access Standards	6. *Thirty (30) minutes or thirty (30) miles, except in rural areas where community standards and documentation shall apply.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA MCO RR Questionaire 10. Provider Network Onboarding Plan FINAL - pg 8 • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network pg 3 section II.G.a.1	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Laboratory and X-Ray Services Access Standards		
42 CFR §438.207(a);(b)(1-2) Contract Exhibit C: General Access Standards	7. *Thirty (30) minutes or thirty (30) miles, except in rural areas where community standards and documentation shall apply.* **Evidence as submitted by the MCO:** • IA MCO RR Questionaire 10. Provider Network Onboarding Plan FINAL - pg 8 • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network pg 3 section II.G.b.1	Y ☒ N ☐
Pharmacy Access Standards		
42 CFR §438.207(a);(b)(1-2) Contract Exhibit C: General Access Standards	8. *Two (2) pharmacy providers within thirty (30) minutes or thirty (30) miles.* **Evidence as submitted by the MCO:** • IA MCO RR Questionaire 10. Provider Network Onboarding Plan FINAL - pg 8 • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network pg 3 section II.G.c	Y ☒ N ☐
Community Based Residential Alternatives		
42 CFR §438.207(a);(b)(1-2) Contract E.1.19	9. *For community-based residential alternatives, the MCO demonstrates good faith efforts to develop the capacity to have a travel distance of no more than sixty (60) miles between a member's community-based residential alternative placement and the member's residence before entering the facility.* **Evidence as submitted by the MCO:** • IA MCO RR Questionaire 10. Provider Network Onboarding Plan FINAL - pg 7 • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – Provider Network - pg 2 section II.D.a	Y ☒ N ☐

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Care Coordination Program		
1. The MCO ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. a. The member is provided information on how to contact their designated person or entity. 42 CFR §438.208(b)(1) Contract G.2.01–G.2.02	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Member materials, such as the member handbook or member notice • Primary care provider (PCP) assignment algorithm • Screenshot of member identification (ID) card • Screenshot of fields within the health information system designating the assigned PCP and assigned case manager • Staff training materials **Evidence as Submitted by the MCO:** • IA_HCS-501.01 Page 3 section D • IA_2023 HCS Program Description, page 58 • IA _Primary CM Assignment Sample • IA_PCP Listing Screenshot • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, pages 49-50, and page 3 Contact Information • IA _Training Agenda - LTSS and mCare Program • IA _Training LTSS Program 101, PPT • IA Medicaid Member ID cards • IA _Welcome and ID Card Backer • IA_PCP and CM Assignment Screenshot • IA_CM Overview.ppt - Slide 10, Trainer notes • IA_MHIA-PCP01_PCP_Selection PnP • IA_LTSS New Hire Training Draft PPT, slide 23	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa, Inc. (“Molina Healthcare of Iowa”) will ensure for each member on a LTSS program, a member will receive an assigned CM who will be the members main point of contact.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
2. The MCO coordinates the services the MCO furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. b. With the services the member receives from any other MCO or PAHP, *including Dual Eligible Special Needs Plans*. c. With the services the member receives in fee-for-service (FFS) Medicaid. d. With the services the member receives from community and social support providers. 42 CFR §438.208(b)(2) Contract G.2.03 Contract G.2.06–G.2.08 Contract G.2.45	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Staff training materials • Transition of care program • Workflow for coordinating with another MCO, including member communication efforts • Workflow for coordinating with dental PAHPs, including member communication efforts • Workflow for coordinating with FFS, including member communication efforts • Workflow for coordinating with community and social support resources, including member communication efforts • Workflow for coordinating with Dual Eligible Special Needs Plans, including dual eligible member communication efforts **Evidence as Submitted by the MCO:** • IA_HCS-513.01, Page 2 – Section I • IA_HCS-513, Page 1 – Purpose and Policy • IA_HCS-509.01, Pages 1-3. • IA_HCS 407.01, Page 3, D.1.a-c • IA Workflows for COC - Workflow for coordinating with another MCO, including member communication efforts, CM to CM Warm Process, slide 1 - Workflow for coordinating with dental PAHPs, including member communication efforts, IA_HHS and Dental PAHP workflow	☒ Met ☐ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	- Workflow for coordinating with FFS, including member communication efforts, FFS Coordination, slide 1 - Workflow for coordinating with community and social support resources, including member communication efforts, Community and Social Support, slide 1 - Workflow for coordinating with Dual Eligible Special Needs Plans, including dual eligible member communication efforts, Dual Eligible and Special Needs, slide 1 • IA_2023 HCS Program Description, pages 58 & 61 • IA _Diversion Training Draft, pptx • IA_LTSS New Hire Training Draft, PPT slides 13 and 27 • IA _Pharm Med Prior Auth. Addendum, Section III. State Variances Reference Table. Variance MHI Pharm 08.1. V.F.5	
MCO Description of Process: Molina Healthcare of Iowa ensures continuity of services between MCO, FFS, and other community supports to ensure timely and appropriate service delivery for our members. Molina will share any relevant and required information when necessary for all appropriate parties involved in the members care. When a member transitions from one setting to another, i.e., from a facility setting to a community setting, the assigned LTSS CM will coordinate care between the different settings. The assigned CM will coordinate services the member receives from any other MCO, PIHP, PACHP, FFS, Medicaid or community/social support providers.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** HSAG recommends that the MCO ensure all care management staff are aware of how to determine which PAHP a member is enrolled in and how to contact the dental PAHPs to coordinate care, as applicable.		
Required Actions: None.		
Clinical Records Documentation		
3. *The MCO maintains in its information system (IS) the information necessary to assist in authorizing and monitoring services as well as providing data necessary for quality assessment and other*	**HSAG Required Evidence:** • Policies and procedures • Screenshots of IS fields • Staff training materials • HSAG will also use the results of the system demonstration	☒ Met ☐ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
evaluative activities, and the information includes all the requirements listed in the Clinical Records Checklist. Contract K.30	• HSAG will also use the results of the Clinical Records Checklist **Evidence as Submitted by the MCO:** • IA_FLS Review ADL-IADL, screenshot • IA_FLS Review Score, screenshot • IA_PCSP Template, pages 7-11 • IA _Clinical Operations High Level HCS CM WFs. • IA _Clinical Ops. High level HCS UM WFs 2023 Draft • IA_HCS-507.01, entire document • IA_LTSS New Hire Training Draft, PPT, slide 64 • IA _Training LTSS – FLSR Training, PPT • IA _Training LTSS – SLR Training, PPT. • IA _Training LTSS-SPT Training, PPT. • IA_ UM System Auth Samples	
MCO Description of Process: Molina Healthcare of Iowa will complete the Functional Level and Service Review tool to assist in the identification of LTSS services that need an authorization. The services authorized for members will also be listed on the Person-Centered Service Plan (PCSP).		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Information Sharing		
4. The MCO shares with HHS or other MCOs and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. 42 CFR §438.208(b)(4) Contract G.2.29	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Workflow for sharing assessment results with HHS and dental PAHPs • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS- 407.01, II. B. pgs. 2-10. • IA_HHS and Dental PAHP workflow	☒ Met ☐ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• IA _In Person Kickoff Training agenda • IA_LTSS New Hire Training agenda • IA_LTSS New Hire Training • IA_HCS-513.01, page 2 Sections J and K. • IA_2023 HCS Program Description, page 58 • IA_HCS-407.01, Section B • IA_LOC Annual Assessment Workflow • IA Information Sharing – Transitions, screenshot • IA_LTSS New Hire Training Draft PPT, slide 34	
MCO Description of Process: Molina Healthcare of Iowa ensures continuity of services between MCO, FFS, and other community supports ensuring timely and appropriate service delivery for our members. Molina will share any relevant and required information when necessary for all appropriate parties involved in the members care.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
5. The MCO ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5) Contract G.2.30	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Provider materials, such as the provider manual and provider contract • Method(s) for monitoring provider member health records • Staff training materials **Evidence as Submitted by the MCO:** • IA Provider Manual 020923. - pages. 12, 14, 68 • IA_HCS-513.01, Page 2 Sections J & K • IA_2023 HCS Program Description, page 58 • IA_LTSS New Hire Training Draft PPT, slide 32	☒ Met ☐ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa ensures continuity of services between MCO, FFS, and other community supports ensuring timely and appropriate service delivery for our members. Molina will share any relevant and required information when necessary for all appropriate parties involved in the members care.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
6. The MCO ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. 42 CFR §438.208(b)(6) Contract G.2.33	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Staff training materials • Method(s) for monitoring adherence to privacy rules **Evidence as Submitted by the MCO:** • IA_2023 HCS Program Description, pages 10-11, 58 • IA_LTSS New Hire Training Draft PPT., slide 56 • IA _Legal Doc. and Auth. for Use and Disclosure, entire document • IA_MHIA HP-03-Section II & III • IA_HIPAA 101 Privacy Training- New Hire	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa ensure that member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** While the MCO submitted a revised HIPAA training that included Iowa-specific privacy laws, the presentation continued to include training specific to the State of Texas, which would not apply to the Iowa Medicaid managed care program. As such, HSAG recommends that the MCO remove the Texas-specific training from the presentation.		
Required Actions: None.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Initial Health Risk Screening		
7. The MCO makes a best effort to conduct an initial screening of each member's needs within ninety (90) days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. 42 CFR §438.208(b)(3) Contract G.2.09–G.2.10 Contract G.2.13	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Initial screening template • Initial screening tracking and monitoring mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA_HCS 161, page 1 • IA_HCS 161.01, pages 1&2 • IA_HCS – 152, page 1 • IA_HCS-152.01, page 1 • IA_ Assessment summary template.docx • IA_CMMT Initial HRS Tracking and Monitoring, screenshot • IA_CCA Assessments - HRA, Condition Specific, and Direct Referral, PPT, training • IA _Unable to Contact, PPT • IA_LTSS New Hire Training Draft, slides 49, 50, 51 • IA_2023 HCS Program Description, page 49	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will make best efforts to conduct an initial screening of each member's needs within 90 days of the enrollment effective date in accordance with 42 CFR 438.208(b)(3); contract G.2.09-G.2.10 and Contract G.2. 13.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
Additional Services for Members with Special Health Care Needs or who Need LTSS		
8. The MCO implements mechanisms to comprehensively assess each Medicaid member identified by HHS and identified to the MCO by HHS as needing long-term services and supports (LTSS) or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. a. The assessment mechanisms use appropriate providers or individuals meeting LTSS services coordination requirements of HHS or MCO as appropriate. 42 CFR §438.208(c)(2) Contract G.2.38–G.2.39	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Documentation (e.g., program description, quality strategy, etc.) defining members with special health care needs and members needing LTSS • Comprehensive assessment template • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA _Molina FCNA • IA Assessment Summary template • IA_HCS-501.01, page 3 Section D2 • IA_HCS-507.01, page 4 Scope • IA_HCS-505.01, page 1 Section B • IA_2023 HCS Program Description page 59 Assessment and SP Section • IA_LTSS Facility Comp Asmt. • IA_Comp-Assess-and-SH-508.2 • IA _Training LTSS - Program 101 PPT • IA _Training LTSS FLSR PPT • IA_ Training LTSS - SLR Training PPT • IA_CCA-Assessments-HRA, Condition Specific, and Direct Referral • IA_LTSS New Hire Training Draft, slide 49	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will complete a comprehensive assessment on each LTSS member that requires a course of treatment or regular care monitoring. Molina uses IA_LTSS Facility Comp Assessment for members who reside in a Nursing Facility. The IA_Comp-Assess-		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
and-SH-508.2 is utilized in the comprehensive assessment of members who are on a Waiver program. The Waitlist members will use the Molina Face to Face Comprehensive Needs Assessment (FCNA) as a comprehensive assessment.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
9. The MCO produces a treatment or service plan for members who require LTSS and members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. 42 CFR §438.208(c)(3) Contract G.2.40–G.2.41	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Care plan template • Service plan template • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA_ICP PPT • IA_CCA 117 Care Plan Example - Basic format • IA_HCS-505.01, page 1, Purpose • IA_2023 HCS Program Description page 48, Care Management • IA_2023 HCS Program Description; Page 59, Service Plans • IA_PCSP Template • IA _Training LTSS Program 101 • IA _Training LTSS FLSR Training • IA_ Training LTSS - SLR Training PPT • IA_ Training LTSS – SPT Training PPT • IA_ Training LTSS Care Plan QRG • IA_LTSS New Hire Training Draft PPT, slide 52	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will assess each LTSS member and develop a Person-Centered Service Plan (PCSP) for each member that were determined to need a course of treatment or regular care monitoring.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		

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Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
10. The treatment or service plan is: a. Developed by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member. b. Developed by a person trained in person-centered planning using a person-centered planning process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans. c. Approved by the MCO in a timely manner in accordance with any applicable HHS quality assurance and utilization review standards. 42 CFR §438.208(c)(3)(i-iv) Contract F.12B.16 Contract G.2.42(a-d)	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Staff qualifications for developing care plans and service plans (e.g., job description) • Service plan approval process • Staff training materials • Mechanisms to solicit provider input into the care plan/service plan **Evidence as Submitted by the MCO:** • IA_HCS-505.01, pages 2 & 3 Section N and T and U • IA_2023 HCS Program Description, page 59 • IA_2023 HCS Program Description Job Description, pages 25 & 26 • IA_PCSP Template • IA _Clinical Operations High level HCS CM Wfs. • IA _Training LTSS Program 101 PPT. • IA _Training LTSS FLSR Training PPT. • IA_ Training LTSS - SLR Training PPT. • IA _Training LTSS-SPT Training PPT. • IA _CM-RN Job Description. • IA_HCS-148, pages 11-22. • IA_HCS-148.01, pages 11-22. • IA_LTSS New Hire Training Draft PPT, slide 52	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will develop a PCSP by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member. The PCSP will be developed by a person trained in person-centered planning using a person-centered planning process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		

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Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
11. The treatment or service plan is reviewed and revised upon reassessment of functional need, at least every twelve (12) months, (*i.e., at least every 365 days in accordance with the Iowa Administrative Code (IAC)),* or when the member's circumstances or needs change significantly, or at the request of the member per 42 CFR §441.301(c)(3) and 42 CFR §441.725(c). 42 CFR §438.208(c)(3)(v) Contract G.2.42(e) IAC 90.22 IAC 90.41(b)	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Care plan and service plan review and revision tracking mechanism • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA_CMMT - Care Plan Report, screenshot • IA_HCS-505.01, page 3, Section O and P • IA_2023 HCS Program Description page 59 • IA _Training LTSS – CM Resp PPT • IA _Training LTSS - FLSR PPT • IA _Training LTSS - Program 101 PPT • IA _Training LTSS - NFCR Process PPT • IA _Training LTSS - SLR Training PPT • IA _Training LTSS Care Plan QRG • IA _Training Agenda - LTSS and mCare Program • IA _Training LTSS - SPT Training, PPT • IA_LTSS New Hire Training agenda • IA_LTSS New Hire Training Draft PPT, slide 32	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa completes PCSP on an initial assessment, annually, and when there is a significant change in the members condition or at the request of the member in accordance with Iowa Administrative Code.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
Direct Access to Specialists		
12. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the MCO has a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. 42 CFR §438.208(c)(4) Contract G.2.44	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Member materials, such as the member handbook or benefits grid • Provider materials, such as the provider manual or provider contracts • Staff training materials • Example of a prior authorization showing a standing referral or an approved number of visits **Evidence as Submitted by the MCO:** • IA_HCS 325.01, II. d. a., page 2 • IA_UM System Auth. Samples.docx • IA_ Combined Roles and CRP Detailed Agenda • IA_ CRC IP Role Specific NEO Agenda • IA_ CRC PA Role Specific NEO Agenda • IA_ UM System Auth Samples.pdf • IA_2023 HCS Program Description, page 58 • IA_ Provider Manual 020923 pages 55 & 60 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, page 29 • IA_LTSS New Hire Training Draft PPT, slide 33	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa does not require referrals for members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, to see specialists. Office visits to in network specialists also do not require authorization.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
State Care Coordination Program Requirements		
13. *The MCO complies with all HHS-required care coordination program requirements as specified in the Care Coordination Checklist.* Contract G.2	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Initial health risk screening tool template • Initial health risk screening tracking and monitoring mechanisms • Comprehensive health risk assessment tool template • Comprehensive assessment tracking and monitoring mechanisms • Risk stratification methodology (i.e., risk level assignments) • Care plan template • Method(s) of disseminating care plan to PCP, other providers, and members • Care plan tracking and monitoring mechanisms • Member outcomes tracking and reporting mechanisms • Method(s) of sharing care coordination information with the member, authorized representatives, and relevant treatment providers • Method(s) for monitoring the effectiveness of the care coordination program • Process for reviewing and updating care plans • Staff training materials • HSAG will use the results of the Care Coordination Checklist • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Care Coordination Checklist • IA_HRS Tool	☐ Met ☒ Not Met

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Requirement	**Supporting Documentation**	**Score**
	• IA_CMMT Initial Health Risk Screening tracking and monitoring screenshot • IA _Molina TCNA • IA _Molina FCNA • IA_CMMT Comprehensive Assessment Tracking and Monitoring screenshot • IA_HCS-151 • IA_HCS-151.01 • IA_CCA Care Plan Example screenshot • IA_HCS 154.01 • IA_CM-Risks Strat-Programmatic Levels PPT. • IA_ICP PPT.pdf • IA_CCA Assessments-HRA, Condition Specific, and Direct Referral • IA_2023 HCS Program Description, page 48 (Care Management description), page. 50 (risk strat), pages. 77-78 (Monitoring of CM program) • IA_ PCP Letter-Participating Mbr. • IA_ Medicaid Std. Care Plan Letter • IA_CMMT - Care Plan Report. • IA_ HCS-404 • IA_HCS- 404.01 • IA_LTSS New Hire Training Draft PPT, slide 32 • IA_ HCS-405 HCS • IA _Annual and Five-Year Quality HCS Work Plan Draft, page 78	
MCO Description of Process: Molina Healthcare of Iowa complies with all HHS-required care coordination program requirements as specified in the Care Coordination Checklist.		
HSAG Findings: Although the MCO provided a demonstration of its Iowa-specific member and provider portals, the portals will not be in production until June 2023. Of note, while the MCO did not provide documentation that confirmed it would conduct an initial health risk screening (HRS) for members who		

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Requirement	**Supporting Documentation**	**Score**
have not been enrolled in the prior 12 months, MCO staff members clarified that they will conduct an HRS on all newly enrolled members regardless of whether a member was disenrolled and reenrolled. As this process is more stringent than contract, this finding was not identified as a deficiency (Care Coordination Checklist—Element 1). **Recommendations:** HSAG recommends the following related to the Care Coordination Checklist elements: • Element 2—The telephonic HRS included a section to document if the member was offered assistance with scheduling an initial primary care provider (PCP) appointment. While the response options for this section were *Yes* or *No*, MCO staff members clarified that if *No* was selected it indicated that it was not applicable (e.g., member already established care with a PCP). As such HSAG recommends the MCO consider updating the telephonic HRS template to indicate *Yes* or *Not Applicable* responses or ensure that the narrative section of the template includes an explanation should *No* be selected. • Elements 5 and 7—The MCO did not provide documentation supporting the 70 percent standard for completing HRSs. However, MCO staff members confirmed understanding of this standard and of the reporting obligations to HHS. As such, HSAG recommends that staff training include awareness of HHS' standard for completing HRSs. • Element 12—The MCO did not have a defined standard for a communication plan with providers; however, MCO staff members explained that outreach to providers would occur as needed and that any feedback would be incorporated into the care plan, as applicable. However, as care plans are required to include a communication plan with providers, HSAG recommends that the MCO ensure staff members are trained on this provision to ensure a provider communication plan is consistently documented within the care plan. • Element 18—While the HCS Program Description verified that the MCO will implement processes to evaluate the care management program, as the MCO is new to the Iowa Medicaid managed care program, HSAG recommends that the MCO implement close monitoring of its care management program and its care managers to ensure it implements all requirements effectively and to ensure it immediately remediates any identified concerns. Additionally, HSAG recommends that its formal care management evaluation process include a review of care management key performance indicators and a care management file review.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Provide confirmation that the member and provider portals are live for the Iowa Medicaid managed care program.		
Transition/Continuity of Care		
14. The MCO implements mechanisms to ensure the continuity of care of members transitioning in and out of the MCO's enrollment pursuant to all requirements in 42 CFR §438.62. The MCO demonstrates the following components are implemented to ensure continuity of care during transitions:	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Member materials, such as the member handbook and welcome packet • Staff training materials	☒ Met ☐ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
a. The member has access to services consistent with the access they previously had and is permitted to retain their current provider for a period of time if that provider is not in the MCO's network. b. The member is referred to appropriate providers of services that are in the network. c. HHS, in the case of FFS, or the MCO that was previously serving the member, fully and timely complies with requests for historical utilization data from the new MCO in compliance with Federal and State law. d. Consistent with Federal and State law, the member's new provider(s) are able to obtain copies of the member's medical records, as appropriate. e. Any other necessary procedures as specified by the Secretary to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization. Possible transitions include but are not limited to: (i) initial program implementation; (ii) initial enrollment with the MCO; (iii) transitions between MCOs during the first ninety (90) days of a member's enrollment; and (iii) at any time for cause as described in Contract Section B.5.05. 42 CFR §438.62(b)(1)(i-vi) Contract G.2.34–G.2.35	• Mechanisms to ensure continuity of care **Evidence as Submitted by the MCO:** • IA_HCS 407.01, B 1-12, D, E, F, pages 2-5 • IA_2023 HCS Program Description page 44 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 page 20 • IA_ Member Welcome packet, zip file • IA_ Combined Roles and CRP Detailed Agenda • IA_ CRC IP Role Specific NEO Agenda • IA_ CRC PA Role Specific NEO Agenda • IA_LTSS New Hire Training Draft PPT, slide 13 and 34	
MCO Description of Process: Molina Healthcare of Iowa ensures COC and access to care for members with existing providers, members receiving current treatments, and prior authorized services at the time of enrollment that fall within continuity of care guidelines and regulatory requirements. Molina will authorize and provide coverage for out of network providers, when necessary, services are not available within the network. Additional staff training content is under development.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
15. *During the first year following the MCO's entry into IA Health Link, with the exception of LTSS, residential services, and certain services rendered to dual diagnosis populations, the MCO honors all existing authorizations for covered benefits for a minimum of ninety (90) days, without regard to whether such services are being provided by contracted or non-contracted providers, when a member transitions to the MCO from another source of coverage.* a. *The MCO honors existing exceptions to policy granted by the Director for the scope and duration designated.* b. *At all other times, the MCO honors all existing authorizations for a minimum of thirty (30) days when a member transitions to the MCO from another source of coverage, without regard to whether services are being provided by contracted or non-contracted providers.* c. *The MCO has policies and procedures to identify existing prior authorizations at the time of enrollment.* d. *When a member transitions to another MCO, the MCO provides the receiving entity with information on any current service authorizations, utilization data, and other applicable clinical information such as disease management or care coordination notes.* e. *The MCO provides for the continuation of medically necessary covered services to newly enrolled members transitioning to the MCO's care regardless of prior authorization or referral requirements.* Contract F.6.10-11 Contract F.16.09 Contract G.2.36 Contract G.3.09(h)	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Member materials, such as the member handbook and welcome packet • Staff training materials • Mechanisms to ensure continuity of care and adherence to required time frames **Evidence as Submitted by the MCO:** • IA_HCS 407.01, II A.1.1, B.1-12 pages 1-2 • IA_2023 HCS Program Description. Page 88 • IA _Welcome Kit, zip folder • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, page 20 • IA_ Combined Roles and CRP Detailed Agenda • IA_ CRC IP Role Specific NEO Agenda • IA_ CRC PA Role Specific NEO Agenda • IA_LTSS New Hire Training Draft PPT, slide 34	☐ Met ☒ Not Met

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Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa ensures COC and access to care for members with existing providers, members receiving current treatments, and prior authorized services at the time of enrollment that fall within continuity of care guidelines and regulatory requirements. Molina will authorize and provide coverage for out of network providers, when necessary, services are not available within the network.		
HSAG Findings: While the draft new hire presentation for LTSS staff members included a topic on transitions, including reasons for transitions and information sharing, HSAG expected to see more thorough training on the initial transition of members effective July 1, 2023. After the site review, the MCO submitted staff training on discharge planning and transitions of care; however, it did not include staff training on the transition of care processes specific to the implementation of the MCO's Medicaid managed care program in Iowa nor the requirements of this element.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Submit staff training addressing all of the following: – Honoring all existing authorizations for, at a minimum, 90 days, regardless of whether services are provided by an in-network or out-of-network provider. – Honoring existing exceptions to policy. – Care management and utilization management responsibilities related to the receipt of member transfer records prior to July 1, 2023. – Care management responsibilities related to coordinating with the relinquishing MCO. – Care management responsibilities related to initiating initial contact with members, conducting assessments, and developing care plans/service plans. – Amount, duration, and scope of LTSS will not change unless a new level of care (LOC) assessment is completed (as stated by MCO staff members during the site review). • Provide confirmation that the MCO's system has been configured to pay claims regardless of prior authorization status and provider network status during the first 90 days of enrollment (as stated by MCO staff members during the site review and reiterated during the May 2023 system demonstration). Please note that this expectation applies to all newly enrolled members during the first year of the MCO's entry into the Iowa Medicaid managed care program and not only for the first 90 days after program implementation (e.g., if the MCO receives a newly enrolled member in August 2023, it must honor existing authorizations for the first 90 days of the member's enrollment date); therefore, the MCO must also submit its plan to ensure new members enrolled after July 1, 2023, will also have existing authorizations honored for the first 90 days of the member's enrollment. • Provide confirmation when member transfer records are received and data are entered into the MCO's system, including authorizations for LTSS members.		

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Requirement	**Supporting Documentation**	**Score**
16. *During the first ninety (90) days following the MCO's entry into IA Health Link, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in Contract Section F.13.28, the MCO allows a member who is receiving covered benefits from a non-network provider at the time of MCO enrollment to continue accessing that provider, even if the network has been closed due to the MCO meeting the network access requirements.* a. *The MCO is permitted to establish single case agreements with providers enrolled with Iowa Medicaid or otherwise authorize non-network care past the initial ninety (90) days of the contract to provide continuity of care for members receiving out-of-network services.* b. *The MCO makes commercially reasonable attempts to contract with providers from whom a member is receiving ongoing care.* c. *Out-of-network providers will be reimbursed a percentage of the network rate unless otherwise agreed upon through a single case agreement.* Contract G.2.37	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Member materials, such as the member handbook and welcome packet • Staff training materials • Single case agreement template • Continuity of care plan **Evidence as Submitted by the MCO:** • IA_HCS 407.01, II A-B, pages 1&2 • IA_ SCA Request Form.docx • IA_ Combined Roles and CRP Detailed Agenda • IA_ CRC IP Role Specific NEO Agenda • IA_ CRC PA Role Specific NEO Agenda • IA _MHC _Member- Handbook _Revised _State-and HSAG_2023 page 20-21 • IA_ HCS-391.01 IA HCS-391.01 Non-Participating Provider PA Requests Procedure_IA RR • IA_ SOP Single Case Agreement Final • IA_ Workflows for COC • IA_LTSS New Hire Training Draft PPT, slide 33	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa ensures COC and access to care for members with existing providers, members receiving current treatments, and prior authorized services at the time of enrollment that fall within continuity of care guidelines and regulatory requirements. Molina will authorize and provide coverage for out of network providers, when necessary, services are not available within the network.		
HSAG Findings: While the draft new hire presentation for LTSS staff members included a topic on transitions, including reasons for transitions and information sharing, HSAG expected to see more thorough training on the initial transition of members effective July 1, 2023. After the site review, the MCO submitted staff training on discharge planning and transitions of care; however, it did not appear to include staff training on the transition of care process specific to the implementation of the MCO's Medicaid managed care program in Iowa or include the requirements of this element.		
Required Actions: In order to receive a *Met* score for this element, the MCO must:		

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Requirement	**Supporting Documentation**	**Score**
• Submit staff training addressing all of the following: – Allowing members to receive services from an out-of-network providers during the first 90 days of the MCO's entry into the Iowa Medicaid managed care program. – Care management responsibilities if a member is identified as receiving services from an out-of-network provider (e.g., notify provider network management to make attempts to contract with the provider). • Provide confirmation that the MCO has identified out-of-network providers via the member transfer records and is actively outreaching to those providers to become in-network providers or seeking an SCA.		
17. *The MCO provides care coordination after the member has disenrolled from the MCO whenever the member disenrollment occurs during an inpatient stay.* a. *Acute inpatient hospital services for members who are hospitalized at the time of disenrollment from the MCO shall be paid by the MCO until the member is discharged from acute care or for sixty (60) days after disenrollment, whichever is less, unless the member is no longer eligible for Medicaid.* b. *Services other than inpatient hospital services (e.g., physician services) shall be paid by the new MCO as of the effective date of disenrollment.* c. *When member disenrollment to another MCO occurs during an inpatient stay, the MCO notifies the new MCO of the inpatient status of the member.* d. *The MCO also notifies the inpatient hospital of the change in MCO enrollment but advises the hospital that the MCO maintains financial responsibility.* Contract G.2.05	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Mechanisms to identify members who are hospitalized when disenrolled and subsequent communication methods • Staff training materials **Evidence as Submitted by the MCO:** • IA_HCS 325.01 II. j 11-12, page 6 • IA_ Combined Roles and CRP Detailed Agenda • IA_ CRC IP Role Specific NEO Agenda • IA_ CRC PA Role Specific NEO Agenda • IA_ Workflows for COC • IA_2023 HCS Program Description pg. 48 • IA_LTSS New Hire Training Draft PPT, slide 13	☒ Met ☐ Not Met
MCO Description of Process: For any members who disenroll during an inpatient stay, Molina Healthcare will notify the new MCO of the members inpatient status and that Molina will be financially responsible until discharge.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendation:** The MCO's policy did not stipulate the following: "Acute inpatient hospital services for members who are hospitalized at the time of disenrollment from the MCO shall be paid by the MCO until the member is discharged from acute care or for sixty (60) days after disenrollment, whichever is less, unless the member is no longer eligible for Medicaid." As such, HSAG recommends that the MCO update its policy accordingly. Additionally, MCO staff members explained that the MCO is not notified of who the receiving MCO is when a member is disenrolled; therefore, the MCO would not be able to notify the receiving MCO. HHS staff members confirmed this was correct during the site review; therefore, this finding was not considered a deficiency.		
Required Actions: None.		
1915(c) and 1915(i) Home- and Community-Based Services (HCBS)		
18. *The MCO delivers HCBS services to all members meeting the eligibility criteria and authorized to be served by these programs. The MCO provides:* a. *Screening of members who appear to be eligible;* b. *Timely completion of the initial and annual comprehensive functional assessment for needs-based eligibility and level of care;* c. *Monitoring of members on the HCBS wait list;* d. *Completion of a social history;* e. *Annual redetermination of needs-based eligibility and level of care;* f. *Service plan review, services monitoring, and authorization;* g. *Claims payment;* h. *Network capacity;* i. *Provider agreement execution;* j. *Rate setting; and* k. *Provider training and technical assistance.* Contract F.12B.01	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Level of care and functional assessment template(s) • Staff training materials • Provider training requirements • HCBS provider agreement template **Evidence as Submitted by the MCO:** • IA_HCS-501.01, page 2 Section B-9 • IA_HCS-505.01, page 3 Section T, W, X • IA_HCS-596.01, page 1 Purpose • IA_HCS-504.01, page 2 Section H • IA_HCS-507.01, page 1 Procedure in entirety • IA_ 2023 HCS Program Description, page 55 • IA_SPT Auth Example Screenshot • IA_LOCMS Workflow • IA_LOCMS Draft Training • IA_LOCMS QRG v3 • IA_LOC Assessment Process Flow • IA_LTSS CM Overview Workflow	☐ Met ☒ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• IA_LTSS Facility Comp Asmt. • IA_PCSP Process Overview • IA_PCSP Template • IA _Waitlist Member Workflow **Level of Care Assessments – Configuration documents:** • IA_SIS-A Interview Form.2015 • IA_SIS-C Interview and Profile form • IA_470-4694 example • IA _InterRAI Peds HC 2014 V9.2.0 • IA _Mayo Portand Config. Document • IA _InterRAI HC V10 Config. Document • IA _InterRAI ChYMH Config Document • IA _InterRAI Adolescent Supplemental (ChYMH-A) v2 • IA_ Off Year Assessment Config Document • IA_Comp-Assess-and-SH-508.2 • IA_2350-MC-FFS_Asst._Tools • IA_LOC Annual Assessment Workflow • IA_LOC Reassessment Workflow • IA _Mockup Pending Assessment Report IA • IA_ Provider Manual 020923, pages 142-146 • IA _Molina Iowa HCBS PSA (FFS) • IA_LTSS New Hire Training Draft PPT, slide 49	
MCO Description of Process: Molina Healthcare of Iowa provides LTSS Care Management to all members who meet the eligibility criteria and are authorized to be served by these programs. The member has a level of care review, a comprehensive care management assessment and social history, development of a care plan and/or service plan and monitoring of service needs and authorization. The Agency has indicated the level of care and needs-based eligibility assessments that are to be used in the process.		
HSAG Findings: Although the MCO demonstrated its care management platform in the testing environment, the platform is not live for Iowa Medicaid managed care.		
Required Actions: In order to receive a *Met* score for this element, the MCO must:		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
• Submit the completed IA_LOCMS QRG and IA_LOCMS Draft Training documents. • Provide confirmation that the care management platform for the Iowa Medicaid managed care program is live.		
19. *The MCO complies with all HHS-required home- and community-based services requirements as specified in the Home- and Community-Based Services (HCBS) Checklist.* Contract F.12B	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Workflow(s) for conducting HCBS level of care (LOC) and needs-based assessments (initial, reassessments, annual assessments) • LOC and Needs-Based Eligibility Assessment tools and corresponding populations. • LOC and Needs-Based Eligibility Assessments tracking and reporting mechanisms • Comprehensive assessment template • Service plan templates, including separate templates, as appropriate, for waiver members (e.g., HCBS waiver, habilitation waiver) • Service plan tracking and reporting mechanisms • Staff training materials • Assessor-specific training requirements • Plan to monitor and oversee service plan requirements • Plan to conduct inter-rater reliability (IRR) oversight • HSAG will use the results of the Home- and Community-Based Services Checklist • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA_HCS-501.01 • IA_HCS-505.01 • IA_HCS-596.01 • IA_HCS-503.01	☒ Met ☐ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• IA_HCS-511.01 • IA_HCS-598 • IA_HCS-599 • IA_HCS-513.01 • IA_2023 HCS Program Description, pages 55-61 • IA_PCSP Template • IA_LOC Assessment Process • IA_2350-MC-FFS-Assmt.Tools **Level of Care Assessments – Configuration documents:** • IA_SIS-A Interview Form.2015 • IA_SIS-C Interview and Profile form • IA_470-4694 • IA _InterRAI Peds HC 2014 V9.2.0 • IA _Mayo Portland Config Document • IA _InterRAI HC V10 Config Document • IA _InterRAI ChYMH Config Document • IA _InterRAI Adolescent Supplemental (ChYMH-A) v2 • IA _Off Year Assessment Config Document • IA_Comp-Assess-and-SH-508.2 • IA_LOC Annual Assessment Workflow • IA_LOC Reassessment Workflow • IA_LOC Change in Condition Workflow • IA_LTSS New Hire Training Draft PPT, slide 32 • Additional staff training content under development	
MCO Description of Process: During the level of care and needs-based eligibility assessment process, Molina Healthcare of Iowa follows the direction provided in IA_2350-MC-FFS-Assessment_Tools_approved for HCBS. The LOCUS and CALOCUS are completed online, and the outcome of the review will be uploaded in our system for CMs to use during care planning and service planning.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Recommendations: The service plan is required to record the alternative home- and community-based settings that were considered by the member. While the MCO's service plan template included a checkoff list that confirms the care manager has educated the member on service alternatives and service delivery options, it did not specially include a field to document those alternative settings considered by the member. MCO staff members clarified that this would be documented in the narrative notes. As such, HSAG recommends that the MCO ensure staff training on this requirement to ensure this documentation expectation is met. Additionally, HSAG recommends the MCO conduct staff training to ensure the service plan is consistently signed by all individuals and providers responsible for its implementation and is distributed to the member and other people involved in the service plan. Further, while the MCO's service plan template and staff training were comprehensive, HSAG recommends that the MCO complete a thorough review of the IAC, specifically IAC 441.78, 441.83, 441.90. As necessary, the MCO should update its service plan and staff training to ensure compliance with all requirements of the IAC. (HCBS Checklist—Element 15).		
Required Actions: None.		
Community-Based Case Management		
20. *The MCO provides for the delivery of community-based case management (CBCM) to all community-based LTSS members, including all of the activities described in Contract Section F.12C and the Iowa Administrative Code (IAC) for members who are receiving services under the 1915(c) and 1915(i) HCBS programs.* a. *Members enrolled in 1915(i) Habilitation and 1915(c) Children's Mental Health (CMH) Waiver may receive care Coordination via the Integrated Health Homes (IHH) in lieu of CBCM with the MCO acting as the lead entity.* Contract F.12C.01	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Written agreement template with the IHHs • Implementation/communication plan for working with the IHHs • Staff training materials • Oversight and monitoring plan for IHHs **Evidence as Submitted by the MCO:** • IA-HCS-501.01- Page 3 Section D-1 • IA_2023 HCS Program Description, page 56 • IA_IHH 101_Provider Facing, slide 9-10 • IA_IHH Policy • IA_IHH Procedure • IA _ Molina Iowa HCBS PSA (FFS) • IA_LTSS New Hire Training Draft PPT, slide 9	☒ Met ☐ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa provides community-based case management (CBCM) to all community-based LTSS members, including all of the activities described in Contract Section F.12C and the Iowa Administrative Code (IAC) for members who are receiving services under the 1915(c) and 1915(i) HCBS programs. Members enrolled in 1915(i) Habilitation and 1915(c) Children's Mental Health (CMH) Waiver may receive care Coordination via the Integrated Health Homes (IHH) in lieu of CBCM with Molina acting as the lead entity. If the member prefers to receive CBCM from Molina, the member will be assigned a Care Manager.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
21. *The MCO complies with all HHS-required community-based case management requirements as specified in the Community-Based Case Management Checklist.* Contract F.12C	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Screenshot of field designating the assigned community-based case manager • Schedule of working hours of community-based case managers during regular business hours • Schedule for after-hours contact for members receiving CBCM • Training materials specific to community-based case managers • Mechanisms to ensure conflict free CBCM • Mechanisms to monitor receipt of services • Processes to monitor CBCM program and individual community-based case managers • Internal and external communication expectations • Staff training materials • HSAG will use the results of the Community-Based Case Management Checklist • HSAG will also use the results of the system demonstration	☒ Met ☐ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCO: • IA_HCS-598, entire document • IA_HCS-598, pages 1 - 2 a.-o. • IA_2023 HCS Program Description, pages 55-61 • IA_LOC Assessment Process Flow • IA_HCBS Service Verification Process 02.01 • IA_IA-HCS-503.01, page 1- Sections A, B, C, and all of E and F. • IA_IA-HCS-503, page 1, Policy • IA_IA-HCS_501.01, page 2 Section B5 • IA_HCS-501, page 1, paragraph 4 • IA _ Primary CM Assignment Sample • IA_HCS-404.01 Procedure • IA_HCS-405.01 Purpose and Procedure • IA_HCS-405 HCS, entire document • IA_HCS-404, entire document • IA_LTSS New Hire Training pdf • IA_PCP and CM Assignment screenshots • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, page 3 & 4 • IA _Training LTSS Program 101, PPT • IA _Training LTSS FLSR Training. PPT • IA_ Training LTSS - SLR Training, PPT • IA Training LTSS SPT Training, PPT • IA _Training LTSS CM Resp., PPT • IA _ Training LTSS NFCR Process • IA_ Diversion Training Draft • IA_LTSS New Hire Training Draft PPT, slide 32	

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa demonstrates compliance with all HHS required community base care management requirements as specified in the corresponding checklist and in accordance with contract provision F.12C.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** While the provider manual described the role of the community-based care manager and included a section titled *PCP Responsibilities in Care Management Referrals*, HSAG recommends that the MCO specifically inform the providers to notify the community-based care manager, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services. Additionally, while the MCO's policies confirmed the MCO's awareness of HHS' LTSS care management monitoring expectations, HSAG recommends that the MCO implement close monitoring of its LTSS care management program and its community-based care managers to ensure it implements all requirements effectively and to ensure it immediately remediates any identified concerns. Additionally, HSAG recommends that its formal LTSS care management evaluation process include a review of LTSS care management key performance indicators, an LTSS care management file review, and considers care management provided by the Integrated Health Homes (IHHs).		
Required Actions: None.		

Standard VI—Coordination and Continuity of Care						
Met	=	17	X	1	=	17
Not Met	=	4	X	0	=	0
Total	=	21	Total Score		=	17
				Total Score ÷ Total	=	81%

Standard VI—Care Coordination Checklist		
Reference	**Required Components**	
Contract G.2.10	1. *The MCO develops a plan to conduct initial health risk screenings for:* a. *New members, within ninety (90) days of enrollment for the purpose of assessing need for any special healthcare or care coordination services;* b. *Members who have not been enrolled in the prior twelve (12) months; and* c. *Members for whom there is a reasonable belief they are pregnant.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ HCS – 161 • IA_HCS - 161.01 • IA_ 2023 HCS Program Description -Page 64	
Contract G.2.10	2. *During the initial health risk screening process, members are offered assistance in arranging an initial visit with their primary care provider (PCP) (as applicable) for a baseline medical assessment and other preventive services, including an assessment or screening of the member's potential risk, if any, for specific diseases or conditions.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA _HRS Tool- page 7	
Contract G.2.11	3. *At minimum, the health risk screening tool assesses the member's physical, behavioral, social, functional, and psychological status and needs.* a. *The tool determines the need for care coordination, behavioral health services, or any other health or community services.* b. *The tool complies with the National Committee for Quality Assurance (NCQA) standard for health risk screenings and contains standardized questions that tie to social determinants of health.* c. *The tool includes the social determinants of health questions as determined by HHS.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ HRS Tool- (highlight IA SDOH questions)	

Standard VI—Care Coordination Checklist		
Reference	**Required Components**	
Contract G.2.12	4. *The initial health risk screening may be conducted in person, by phone, electronically through a secure website, or by mail.* a. *The MCO develops methods to maximize contacts with members in order to complete the initial health screening.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ HCS – 161 • IA_ HCS - 161.01	
Contract G.2.13	5. *Each quarter, at least seventy (70) percent of the MCO's new members, who have been assigned to the MCO for a continuous period of at least ninety (90) days, complete an initial health risk screening within ninety (90) days.* a. *For any member who does not obtain an initial health risk screening, the MCO documents at least three (3) attempts to conduct the screening.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-152 • IA_ HCS-152.01	
Contract G.2.14	6. *The MCO conducts a subsequent health screening if a member's healthcare status is determined to have changed since the original screening, or every twelve (12) months, whichever is sooner.* a. *Subsequent screenings include standardized questions that tie to social determinants of health.* b. *Such evidence may be available through methods such as claims review or provider notification.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA HCS-161 • IA-HCS-161.01 • IA_Iowa HRS Tool	

Standard VI—Care Coordination Checklist		
Reference	**Required Components**	
Contract G.2.15	7. *Each quarter, at least seventy (70) percent of the MCO's members who are due for subsequent health risk screening, who have been assigned to the MCO for a continuous period of at least twelve (12) months, complete an initial health risk screening within twelve (12) months of the last initial or comprehensive health risk screening or last health risk screening attempt.* a. *For any member who does not obtain a subsequent health risk screening, the MCO documents at least three (3) attempts to conduct the screening.* b. *Demonstrated good faith efforts of these three (3) attempts which result in the unsuccessful completion of a member's health risk screening will be excluded from the seventy (70) percent threshold calculation.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA HCS-161 • IA-HCS-161.01	
Contract G.2.18	8. *The MCO determines a time frame in which all comprehensive health risk assessments must be completed for all members.* a. *The MCO implements and adheres to the HHS-approved timeline.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-162 • IA_HCS-162.01	
Contract G.2.19	9. *The MCO utilizes risk stratification levels to determine the intensity and frequency of follow-up care that is required for each member participating in the care coordination program.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-151 • IA_HCS-151.01	
Contract G.2.20	10. *In addition to identifying members eligible for the care coordination program through the initial health risk screening and comprehensive health risk assessment, the MCO utilizes, at minimum: (i) industry standard predictive modeling; (ii) claims review; (iii) member and caregiver requests; and (iv) physician referrals.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-151 • IA_HCS-151.01	

Standard VI—Care Coordination Checklist		
Reference	**Required Components**	
Contract G.2.22	11. *The MCO develops a care plan for all members eligible for the care coordination program.* a. *The care plan is individualized and person-centered based on the findings of the health risk screening, health risk assessment, available medical records, and other sources needed to ensure that care for members is adequately coordinated and appropriately managed.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-154 • IA_HCS-154.01 • IA_ 2023 HCS Program Description -Page 52	
Contract G.2.22	12. *The care plan:* a. *Establishes prioritized, measurable goals and actions with defined outcomes;* b. *Facilitates seamless transitions between care settings;* c. *Creates a communication plan with providers and members;* d. *Monitors whether the member is receiving the recommended care.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-154.01 • IA_ 2023 HCS Program Description -page 46, 52, 53	
Contract G.2.23	13. *When developing the care plan, in addition to working with a multidisciplinary team of qualified healthcare professionals including specialists caring for the member, the MCO ensures that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be actively involved in the care plan development.* a. *Care plans are conducted jointly with other caseworkers for members who are accessing multiple services concurrently or consecutively.* b. *The MCO provides an integrated care plan which avoids duplication and/or fragmentation of services.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-154 • IA_HCS-154.01	

Standard VI—Care Coordination Checklist		
Reference	**Required Components**	
	• IA_HCS-148.01, II. Procedure, B.1 • IA_ 2023 HCS Program Description - pg. 5 • IA_ Workflows for COC - CM-CM warm handoff • IA_HCS-505.01 Page 3 Section T.	
Contract G.2.24	14. *The care plan reflects cultural considerations of the member.* a. *The care plan development process is conducted in plain language and be accessible to members who have disabilities and/or have limited English proficiency (LEP).*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-154.01 • IA 2023 HCS Program Description -Page 52	
Contract G.2.24	15. *The MCO ensures that the care plan is provided to the member's PCP (if applicable) or other significant providers.* a. *The MCO also provides the member the opportunity to review the care plan as requested.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS 154.01	
Contract G.2.25	16. *The MCO integrates information about members in order to facilitate positive member outcomes through care coordination.* a. *The system has the ability to track the results of the health risk screening, comprehensive health risk assessment, the care plan, and member outcomes and have the ability to share care coordination information with the member, their authorized representatives, and all relevant treatment providers, including, but not limited to: (i) behavioral health providers; (ii) PCPs; and (iii) specialists.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_CMMT Initial Health Risk Screening tracking and monitoring screenshot.docx • IA_CMMT Comprehensive asst. TM screenshot.docx • IA_CMMT-Care Plan Report.docx • IA_CCA 117 Care Plan Example-basic format.docx	

Standard VI—Care Coordination Checklist		
Reference	**Required Components**	
Contract G.2.21	17. *The MCO designs and operates a care coordination program to monitor and coordinate the care for members identified as having a special healthcare need. Minimum requirements for the MCO's care coordination program include:* a. *Catastrophic case management;* b. *Disease management;* c. *Programs to target members underusing, overusing, and/or abusing services;* d. *Discharge planning; and* e. *Transition planning.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA 2023 HCS Program Description -Page, 45, 46, 53, 55, 67, 68	
Contract G.2.27	18. *The MCO develops a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its care coordination program and processes.* a. *The MCO promptly remediates all case specific findings identified through the monitoring process and tracks and trends findings to identify systemic issues of poor performance or noncompliance.* b. *The MCO implements strategies to improve its care coordination program and processes and resolves areas of noncompliance.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA 2023 HCS Program Description, pgs. 77-78 (Monitoring of CM program)	
Contract G.2.28	19. *The MCO develops a process for reviewing and updating the care plans with members on an as needed basis, but no less often than annually.* a. *Members may move between stratified levels of care groups over time as their needs change; therefore, the MCO must develop a protocol for reevaluating members periodically to determine if their present care levels are adequate.* b. *The MCO identifies triggers that would immediately move the member to a more assistive level of service.* c. *Any member or provider can request a reassessment at any time.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-154 • IA_HCS-154.01 • IA_HCS-162 • IA_HCS-162.01	

Standard VI—Community-Based Case Management Checklist		
Reference	**Required Components**	
Contract F.12C.01	1. *Unless enrolled in an Integrated Health Home (IHH), the MCO assigns to each member receiving long-term services and supports (LTSS) a community-based case manager who is the member's main point of contact with the MCO and their service delivery system. The MCO provides for the delivery of Community-Based Case Management (CBCM) to all community-based LTSS enrolled members, including all of the activities described in section F.12.C of the contract and the Iowa Administrative Code for members who are receiving services under the 1915(c) and 1915(i) HCBS programs. CBCM meets all of the applicable requirements as specified in Iowa Admin. Code chs. 441-78.27, 441-83 and 441-90.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_2023 HCS Program Description Page 56 • IA_HCS-501.01 Page 3 – Section D1	
Contract F.12C.01	2. *The MCO establishes mechanisms to ensure ease of access and a reasonable level of responsiveness for each member to their community-based case manager during regular business hours.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_2023 HCS Program Description Page 34 and 57	
Contract F.12C.01	3. *The MCO provides for after-hours contact for members receiving community-based case management (CBCM).*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_2023 HCS Program Description Page 34 and 57	
Contract F.12C.01–F.12C.02	4. *Community-based case manager staff have knowledge of community alternatives for the LTSS population, and the full range of LTSS resources as well as specialized knowledge of the conditions and functional limitations of the target populations served by the MCO, and of the individual members to whom they are assigned.* a. *For members who choose to self-direct services through the Consumer Choices Option (CCO) program, the community-based case manager has specific experience with self-direction and additional training regarding self-direction.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-503.01page 1 section B4 and B8, 2 Section E,	

Standard VI—Community-Based Case Management Checklist		
Reference	**Required Components**	
Contract F.12C.02	5. *The MCO defines the required qualifications, experience, and training of community-based case managers.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_2023 HCS Program Description Page 25 Entire Section • IA_HCS-503.01 Page 1- Sections A, B, C, and all of E and F. • IA_HCS-503 Page 1 – under Policy	
Contract F.12C.01	6. *The MCO ensures CBCM is provided in a conflict free manner that administratively separates the final approval of 1915(c) and 1915(i) HCBS program plans of care from the approval of funding amount determined by the MCO.* a. *CBCM efforts made by the MCO, or its designee, avoid duplication of other coordination efforts provided within the members' systems of care.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS_501.01 Page 2 Section B5 • IA_HCS-501 Page 1 Paragraph 4	
Contract F.12C.03	7. *The MCO facilitates access to covered benefits and monitors the receipt of services to ensure members' needs are being adequately met.* a. *The MCO maintains ongoing communications with a member's community and natural supports to monitor and support their ongoing participation in care.* b. *The MCO coordinates with stakeholders funding non-Medicaid covered services and supports to the member that are important to the member's health, safety, and well-being and/or impact a member's ability to reside in the community.* c. *The MCO implements strategies to coordinate and share information with a member's service providers across the health care delivery system, and to facilitate a comprehensive, holistic, and person-centered approach to care, and to address issues and concerns as they arise.* d. *The MCO provides assistance to members in resolving concerns about service delivery or providers.* e. *The MCO provides to service providers information regarding the role of the community-based case manager and requests that providers notify a community-based case manager, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services.*	Y ☒ N ☐

Standard VI—Community-Based Case Management Checklist		
Reference	**Required Components**	
	f. *The MCO ensures adequate and timely communication and sharing of records with other MCOs in the event that a member transitions from one MCO to another to prevent interruption or delay in the member's service delivery.*	
	Evidence as submitted by the MCO: • IA_HCS-513.01 Page 2 Section J and K • IA_HCS-505.01 Page2, section N, Page 3, section U, Page 3-4 section Y • IA_2023 Program Description Page 60 • IA_HCS-407.01 Section C	
Contract F.12C.04	8. *The MCO implements strategies to ensure there is internal communication among its departments to ensure community-based case managers are made aware of issues relevant to the members on their assigned caseload (e.g., policy clarifications, informational letters, hospitalization and emergency room notifications, critical incidents, etc.).* a. *This includes ensuring that community-based case managers have timely access to Medicaid and LTSS eligibility changes and updates.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_2023 HCS Program Description Page 57	
Contract F.12C.05	9. *The MCO permits members to change to a different community-based case manager if the member desires and there is an alternative community-based case manager available.* a. *Such availability may take into consideration the MCO's need to efficiently deliver CBCM in accordance with the requirements of the Contract.* b. *In order to ensure quality and continuity of care, the MCO makes efforts to minimize the number of changes in a member's community-based case manager.* c. *Examples of when MCO-initiated change in community-based case managers may be appropriate include, but are not limited to, when the community-based case manager: (i) is no longer employed by the MCO; (ii) has a conflict of interest and cannot serve the member; (iii) is on temporary leave from employment; or (iv) has caseloads that must be adjusted due to the size or intensity of the individual community-based case manager's caseload.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA-HCS-599 Page 1 – under Policy	

Standard VI—Community-Based Case Management Checklist		
Reference	**Required Components**	
Contract F.12C.05	10. *The MCO develops, implements, and adheres to policies and procedures regarding notice to members of community-based case manager changes initiated by either the MCO or the member, including advance notice of planned community-based case manager changes initiated by the MCO.* a. *The MCO ensures continuity of care when community-based case manager changes are made, whether initiated by the member or the MCO.* b. *The MCO demonstrates use of best practices by encouraging newly assigned community-based case managers to attend a face-to-face transition visit with the member and the outgoing community-based case manager when possible.* c. *The MCO develops, implements, and adheres to policies and procedures to provide seamless, effective case management transition for the members from fee-for-Service (FFS) to managed care, and from one MCO to another.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-599 Page 2	
Contract F.12C.06	11. *The MCO develops, implements, and adheres to policies and procedures to ensure that community-based case managers are actively involved in discharge planning when an LTSS member is hospitalized or otherwise served outside of the home.* a. *The MCO defines circumstances that require that hospitalized members receive an in-person visit to complete a needs reassessment and an update to the member's plan of care.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-505.01 Page 3 – Top of page • IA_HCS-501.01 Page 6 – Section S	
Contract F.12C.07	12. *The MCO ensures that each in-person visit by a community-based case manager to a member includes observations and documentation of the following:* a. *The member's physical condition including observations of the member's skin, weight changes, and any visible injuries;* b. *The member's physical environment;* c. *The member's satisfaction with services and care;* d. *The member's upcoming appointments;* e. *The member's mood and emotional well-being;* f. *The member's falls and any resulting injuries;*	Y ☒ N ☐

Standard VI—Community-Based Case Management Checklist		
Reference	**Required Components**	
	g. *A statement by the member regarding any concerns, questions, gaps in services, or unmet needs; and* h. *A statement from the member's representative or caregiver regarding any concerns or questions (if representative/caregiver is available).*	
	Evidence as submitted by the MCO: • IA_HCS-501.01 Pages 6 section U and continued Page 7	
Contract F.12C.08	13. *At a minimum, the community-based case manager or care coordinator contacts 1915(c) and 1915(i) HCBS members either in person or by telephone at least monthly.* a. *Members are visited in their residence face-to-face by their community-based case manager or care coordinator as frequently as necessary but at least every three (3) months.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-501.01 Page 7 – Section V	
Contract F.12C.09	14. *The MCO identifies, documents, and immediately remediates problems and issues including but not limited to safety concerns, service gaps, changes in needs or circumstances, and complaints or concerns regarding the quality of care rendered by providers, workers, or CBCM staff.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-501.01 Page 6 Section R • IA_2023 Program Description Page 58	
Contract F.12C.10	15. *The MCO develops a comprehensive program and description for monitoring, on an ongoing basis, the effectiveness of its CBCM processes. The MCO:* a. *Immediately remediates all individual findings identified through its monitoring process;* b. *Tracks and trends such findings and remediation to identify systemic issues of marginal performance and/or non-compliance;* c. *Implements strategies to improve CBCM processes and resolve areas of noncompliance or member dissatisfaction; and* d. *Measures the success of such strategies in addressing identified issues.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-598 Page 1 – under Policy	

Standard VI—Community-Based Case Management Checklist		
Reference	**Required Components**	
Contract F.12C.10	16. *At a minimum, the MCO monitors the following:* a. *CBCM tools and protocols are consistently and objectively applied and outcomes are continuously measured to determine effectiveness and appropriateness of processes;* b. *Level of care and reassessments occur on schedule;* c. *Comprehensive needs-based assessments and reassessments, as applicable, occur on schedule and in compliance with the Contract;* d. *Care plans are developed in accordance with 42 CFR §438.208(c)(3)(i)-(v), by a person trained in person-centered planning using a person-centered process and plan, with member participation and provider consultation; and updated on schedule and in compliance with the Contract;* e. *Care plans reflect needs identified in the comprehensive needs assessment and reassessment process;* f. *Care plans address all of the member's needs;* g. *Services are delivered as described in the care plan and authorized by the MCO;* h. *Services and providers are appropriate to address the member's needs, and in accordance with 42 CFR §438.208(c)(4), the MCO allows members with special health care needs determined through an assessment in accordance with 42 CFR §438.208(c)(2) to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the member's condition and identified needs;* i. *Services are delivered in a timely manner;* j. *Service utilization is appropriate;* k. *Service gaps are identified and addressed;* l. *Minimum community-based case manager contacts are conducted;* m. *Community-based case manager-to-member ratios are appropriate and do not exceed HHS-identified maximums; and* n. *Service limits are monitored and appropriate action is taken if a member is nearing or exceeds needs-based service limits outlined in the service plan. Appropriate action includes assessment of whether the service plan requires revision to allocate additional units of waiver services or if other non-waiver resources are available to meet the member's needs in the community.* o. *A critical incident or involuntary discharge must result in an audit of case management activities and development of a remediation plan to include CBCM training where appropriate.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-598 Pages 1 through two a.-o.	

Standard VI—Clinical Records Checklist		
Reference	**Required Components**	
The MCO maintains in its IS the information necessary to assist in authorizing and monitoring services as well as providing data necessary for quality assessment and other evaluative activities, including but not limited to:		
Contract K.30(a)	1. *Diagnosis: documentation of the diagnosis and functional assessment score.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-507.01 Page 1 section 1, Page 2 Table, Page 3 Section 3 A-I • IA_FLS Review Score Screenshot • IA_Assessment Summary Template	
Contract K.30(b)	2. *Level of Functioning: determination of and documentation of the levels of functioning.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-507.01 Page 1 section 1, Page 2 Table, Page 3 Section 3 A-I • IA_FLS Review ADL-IADL Screenshot example.	
Contract K.30(c)	3. *Services Authorized: documentation of clinical services requested, services authorized, services substituted, and services provided; documentation reflects the application of UM criteria.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-507.01 Page 1 section 1, Page 2 Table, Page 3 Section 3 A-I • IA_FLS Review ADL-IADL Screenshot example • IA_ UM System Auth Samples • IA_ Clinical Operations High Level HCS UM WFs 2023	
Contract K.30(d)	4. *Services Denied: documentation of services not authorized, reasons for the non-authorization based on Iowa Administrative Code citations (i.e., rationale for the medical professional reviewer's determination based on medical necessity or other criteria), and substitutions offered.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ UM System Auth Samples	

Standard VI—Clinical Records Checklist		
Reference	**Required Components**	
Contract K.30(e)	5. *Missed Appointments: documentation of missed appointments and subsequent attempts to follow up with the member.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ LTSS Missed Service Assessment pdf • IA_HCS 512.01 Page 1 section C and page 2 section E and F.	
Contract K.30(f)	6. *Emergency Room: follow-up on members discharged from the emergency room without an admission for inpatient treatment or observation.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_ED Letter.docx • IA_Medicaid_Emergency_UrgentCare_flyr. • IA_Identification ER Dept. Visits QRG	
Contract K.30(g)	7. *Treatment Planning: documentation of joint treatment planning, clinical consultation, or other interaction with the member or providers and/or funders providing or seeking to provide services to the member.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_PCSP Template - Page 3 and 7 • IA_ICP with ICT recommendations.docx • IA_ICT worksheet v2 assessment template.docx • IA_ICT worksheet v2 assessment QRG	
Contract K.30(h)	8. *Medication Management: documentation of the member's medication management done by the MCO's clinical staff.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_Medication module screenshot.	
Contract K.30(i)	9. *Inpatient Data: documentation of assessment and determination of level at admission, continued service, and discharge criteria.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA _UM System Auth Samples	

Standard VI—Clinical Records Checklist		
Reference	**Required Components**	
Contract K.30(j)	10. *Joint Treatment Planning: name(s) of persons key to the treatment planning of members who access multiple services.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA-PCSP Template pages 3 and 7. • IA_ICT v2 worksheet assessment template.docx • IA_ICT v2 worksheet assessment QRG	
Contract K.30(k)	11. *Discharge Planning: documentation of the discharge plan for each member discharged from twenty-four (24) hour services reimbursed through the MCO; this includes the destination of the member upon discharge.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_Discharge Disposition and Discharge Date screenshots.docx • IA_ UM System Auth Samples	

Standard VI—Home- and Community-Based Services Checklist		
Reference	**Required Components**	
Contract F.12B.02	1. *The MCO provides long-term services and supports (LTSS) in a setting that complies with the 42 CFR §441.301(c)(4) requirements for home- and community-based settings.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_2023 Program Description Page 56	
Contract F.12B.03	2. *In the event there is a waiting list for a 1915(c) waiver, at the time of application, the MCO advises the member there is a waiting list and that they may choose to receive other non-waiver support services because 1915(c) waiver enrollment is not immediately available.* a. *The MCO provides regular outreach to ensure that members are receiving all necessary services and supports to address all health and safety needs while on the wait list.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-596.01 - Page 1 – under Purpose	
Contract F.12B.03	3. *Members are awarded waiver slots by HHS.* a. *When a member is in a facility and qualifies for a reserved capacity slot, HHS will work with the MCO for slot release.* b. *The MCO ensures that each member has obtained supporting documentation necessary to support eligibility for the particular waiver.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-596.01 - Page 3 – section S	
Contract F.12B.03	4. *The MCO ensures that the number of members assigned to LTSS is managed in such a way that ensures maximum access, especially for home- and community-based services (HCBS) community integrated services, while controlling overall LTSS costs.* a. *Achieving these goals requires that HHS and the MCO jointly manage access to LTSS.* b. *The MCO provides HHS with LTSS utilization information at regularly specified intervals in a specified form.* c. *HHS will convene regular joint LTSS access meetings with all MCOs.* d. *The purpose of the meetings will be to collaboratively and effectively manage access to LTSS.* e. *Except as specified, the MCO does not add members to LTSS without HHS' authorization resulting from joint LTSS access meetings.*	Y ☒ N ☐

Standard VI—Home- and Community-Based Services Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCO: • IA_2023 Program Description Page 57-58	
Contract F.12B.04	5. *The expectations in Contract Section F.12B.02 notwithstanding, the MCO authorizes all admissions of members that meet level of care requirements to nursing facilities (NFs) and intermediate care facilities (ICFs) for individuals with intellectual disabilities (ID) that have a contract in good standing with the MCO.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_2023 Program Description Page 37	
Contract F.12B.05	6. *Upon notification from HHS of availability of an open 1915(c) waiver slot, the MCO conducts a comprehensive assessment, in accordance with 42 CFR §438.208(c)(2), as described, using a tool and process for the waitlisted member.* a. *The MCO refers members who are identified as potentially eligible for LTSS to HHS or its designee for level of care determination, if applicable.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-596.01 – Page 1 section B and 3 section R	
Contract F.12B.06	7. *The MCO performs level of care (LOC) and needs-based assessments for their members.* a. *HHS has designated the tools (according to the Iowa Administrative Code [IAC]) that will be used to determine the LOC and comprehensively assesses supports needed for members wishing to access HCBS.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-501.01 – Page 1 paragraph 3	
Contract F.12B.07	8. *HHS is responsible for performing initial LOC assessments for 1915(c) HCBS waiver and needs-based eligibility assessments for 1915(i) habilitation members who are applying for initial Medicaid LTSS eligibility.* a. *The MCO provides members any necessary information regarding the waiver application process.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-501.01 – Page 1 Paragraph 3 and paragraph 4	

Standard VI—Home- and Community-Based Services Checklist		
Reference	**Required Components**	
Contract F.12B.08	9. *The MCO ensures that LOC and needs-based eligibility assessments for members potentially eligible for 1915(c) and 1915(i) HCBS programs includes an assessment of the member's ability to have their needs met safely and effectively in the community and at a reasonable cost to HHS.* a. *If a member's needs exceed limits established in the IAC or the approved 1915(c) waivers, the MCO has discretion to authorize services that exceed those limits.* *PCSP built those services.* b. *If required, the MCO can submit an exception to policy to HHS to exceed limits outlined in the IAC.* c. *If a member does not appear to meet enrollment criteria, the MCO complies with the requirements related to the appearance of ineligibility.* d. *The MCO establishes timelines that will promptly assess the member's needs and ensure member safety.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-501.01 – Page 2 B-10	
Contract F.12B.09	10. *Once the assessment is completed, the MCO submits the LOC or needs-based eligibility assessment to HHS in the manner prescribed by HHS.* a. *HHS will retain all authority for determining Medicaid categorical, financial, and LOC eligibility and enrolling members into a Medicaid eligibility category.* b. *HHS will notify the MCO when a member has been enrolled in a 1915(c) HCBS waiver eligibility category or 1915(i) HCBS program and any applicable Client Participation amounts.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-501.01 Page 6 Section Q	
Contract F.12B.10	11. *The MCO administers all HCBS LOC and needs-based eligibility assessments in accordance with the following requirements:* a. *Members have the ability to have others present of their choosing;* b. *Members and chosen team members shall receive notice to schedule no less than fourteen (14) days prior to current assessment end date;* c. *Members and chosen team members receive a copy of the completed assessment within three (3) business days of the assessment;*	Y ☒ N ☐

Standard VI—Home- and Community-Based Services Checklist		
Reference	**Required Components**	
	d. *Members and chosen team members receive information related to the assessment results in a manner that is meaningful to the team;* e. *Assessments are conflict-free and firewalled from case management and utilization management (UM) functions;* f. *Assessors are trained either by the organization that developed the assessment tool or by an individual directly trained by the organization that developed the assessment tool;* g. *Assessors are trained in appropriate administration of the identified assessment tool in line with best practice for the tool administered;* h. *Assessors actively participate in the inter-rater reliability (IRR) oversight and monitoring activities to ensure fidelity in the assessment process;* i. *Where applicable, assessment results are drawn using a valid sample size to evaluate the IRR of the assessment administration; and* j. *Any assessment determined to be inappropriately derived during evaluation is re-administered within thirty (30) days of findings.*	
	Evidence as submitted by the MCO: • IA_HCS-501.01-Page 2 Section B 1-8 • IA_HCS-503.01- Page 3 - Section G • IA_HCS-503.02 State Variance Reference Table in Entirety	
Contract F.12B.11	12. *Reassessments are completed within twelve (12) months of the previous assessment or more frequently as warranted by a significant change in a member's need or situation.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-501.01- Page 2 Section B9	
Contract F.12B.12	13. *The MCO develops policies and procedures:* a. *Identifying a timeline in which all needs assessments are completed: (i) upon initial enrollment with the MCO; and (ii) when the MCO becomes aware of a change in the member's circumstances which necessitates a new assessment;* b. *Providing that reassessments are conducted, at least every twelve (12) months; and* c. *Identifying a mechanism for completing needs assessments in an appropriate and timely manner.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-501.01- page 2 Section B9 and 9a, Page 4 number 6	

Standard VI—Home- and Community-Based Services Checklist		
Reference	**Required Components**	
Contract F.12B.13	14. *The MCO submits documentation to HHS, in the time frames described in Contract Section F.12B.12 and in the format determined by HHS, for all reassessments that indicate change in the member's 1915(c) LOC or needs-based eligibility for the 1915(i) HCBS programs.* a. *HHS or its designee has final review and approval authority for any reassessments that indicate a change.* b. *The MCO complies with the findings of HHS or its designee in these cases.* c. *If the LOC reassessment or needs-based eligibility reassessment indicates no change in LOC or needs-based eligibility, the member is approved to continue participation in the 1915(i) or 1915(c) HCBS program at the already established LOC for the particular waiver.* d. *The MCO maintains the ability to track and report on LOC or needs-based eligibility reassessment data, including but not limited to, the date the reassessment was completed.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA-HCS-501.01- Page 6 Section Q • IA_ LOCMS Workflow • IA_ LOCMS QRG • IA_ LOCMS Draft Training • IA_ Mockup Pending Assessment Report • IA_LTSS New Hire Training, Page 49	
Contract F.12B.14	15. *The MCO provides service plan development for each HCBS member.* a. *The MCO includes how it will ensure that all components of the service plan process will meet contractual requirements, as well as State and Federal regulations and policies, including 42 CFR §438.208(c)(3)(i)-(v), 42 CFR §441.301(c), and 42 CFR §441.725.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-505.01- Page 3 Section V • IA_PCSP Template – Entirety as a sample • IA_2023 Program Description Page 59 -61	

Standard VI—Home- and Community-Based Services Checklist		
Reference	**Required Components**	
Contract F.12B.15	16. *The MCO ensures service plans are completed within thirty (30) days of notification by HHS of LOC or needs-based eligibility approval, and that the service plan is approved prior to the provision of HCBS services.* a. *The MCO ensures service plans are reviewed and revised: (i) at least every twelve (12) months; or (ii) when there is significant change in the member's circumstance or needs; or (iii) at the request of the member.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-505.01- page 3 Section X • IA_2023 Program Description Page 59	
Contract F.12B.16	17. *The MCO ensures that the HCBS service plan is established through a person-centered service planning process that is led by the member or representative.* a. *The member's representative has a participatory role, as needed and as defined by the member.* b. *The MCO establishes a team for the member that includes the case manager, member, family, providers, integrated health home (IHH) care coordination staff, and others as appropriate and desired by the member.* c. *The MCO implements the level of services and supports as identified by the interdisciplinary team's assessment of the member's needs and as documented in the member's comprehensive person-centered service plan.* d. *The MCO ensures that the comprehensive person-centered service plan identifies an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or when the member's needs change.* e. *The MCO ensures compliance with the person-centered planning process.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-505.01 - Page 1 paragraph, Page 2 section C, and Page 3 section T • IA_HCS-598 – Page 1section A-O	
Contract F.12B.17	18. *In accordance with 42 CFR §441.301 and §441.725, IAC Chapter 441-90, IAC Chapter 441-83, and IAC Chapter 441-78, the MCO ensures the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports.* a. *The service plan reflects the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports.*	Y ☒ N ☐

Standard VI—Home- and Community-Based Services Checklist		
Reference	**Required Components**	
	b. *The person-centered service planning process shall be holistic in addressing the full array of medical and non-medical services and supports regardless of funder to ensure the maximum degree of integration and the best possible health outcomes and member satisfaction.*	
	Evidence as submitted by the MCO: • IA_HCS-505.01- Page 3 section Y, U	
Contract F.12B.18	19. *The MCO ensures the service plan has an emergency plan documented that identifies the supports available to the member in situations for which no approved service plan exists and that, if not addressed, may result in injury or harm to the member or other persons or in significant amounts of property damage.* a. *Emergency plans include, at minimum: (i) the member's risk assessment and the health and safety issues identified by the member's team; (ii) the emergency backup support and crisis response system; and (iii) emergency backup staff designated by providers for applicable services.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-505.01- Page 3 Section W, • IA_HCS-511.01- Page 3 Section H and I	
Contract F.12B.19	20. *The MCO develops, implements, and adheres to policies and procedures describing measures to be taken by the MCO to address instances when a member refuses to sign a service plan, including an escalation process that includes a review of the reasons for the member's refusal as well as actions take to resolve any disagreements with the service plan.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-505.01 – Page 4 Section EE, FF	
Contract F.12B.20	21. *After the initiation of services identified in the member's service plan, the MCO implements strategies to monitor the provision of services, at both residential and nonresidential settings (e.g., employment, day programming, etc.), to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan and are meeting the member's identified needs.* a. *At minimum, the community-based case manager or the care coordinator shall contact 1915(c) and 1915(i) HCBS members within five (5) business days of scheduled initiation of services to confirm that services are being provided and that the member's needs are being met.* b. *This initial contact may be conducted via phone.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-505.01 – page 4 Section AA	

Standard VI—Home- and Community-Based Services Checklist		
Reference	**Required Components**	
Contract F.12B.20	22. *The MCO develops, implements, and adheres to policies and procedures for:* a. *Identifying, responding to, and resolving service gaps; and* b. *Ensuring that the service plan, emergency plan, and back-up plans are implemented and functioning effectively.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-505.01 – page 4 Section BB	
Contract F.12B.20	23. *The MCO develops policies and processes for identifying changes to a member's risk and for addressing any changes, including, but not limited to an update to the member's risk assessment and person-centered service plan.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-505.01 – Page 3 - Section P	
Contract F.12B.21	24. *There are certain conditions that must be met for an individual to be eligible for a 1915(c) HCBS waiver or 1915(i) State Plan HCBS.* a. *The MCO tracks the information described in Contract Section F and notifies HHS, in the manner prescribed by HHS at any time a member appears to be ineligible.* b. *This notice obligation includes any appearance of ineligibility under IAC chapter 441-83 or IAC chapter 441-78.27.* c. *HHS has sole authority for determining if the member will continue to be eligible under the 1915(c) HCBS waiver or 1915(i) State Plan HCBS program, and the MCO complies with HHS' determination.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • Program Description Page 56-57	
Contract F.12B.22	25. *The MCO notifies HHS if an HCBS waiver member is non-compliant with utilization of at minimum one (1) unit of service per calendar quarter or non-compliant with the MCO's contractual oversight obligations.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA_HCS-505.01 – Page 4 – Section DD	
Informational Letter NO.1842-MC-FFS Contract G.5.02(l)	26. *The MCO annually completes the HCBS Residential Setting Member Assessment Form 470-5466 for each HCBS waiver member and subsequently uploads the completed form to the Iowa Medicaid Portal Application (IMPA).*	Y ☒ N ☐
	Evidence as submitted by the MCO: IA_HCS-505.01 – Page 4 Section FF paragraph 2	

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Utilization Management Program		
1. *The MCO develops, operates, and maintains a utilization management (UM) program, which is documented in writing.* a. *The UM program assigns responsibility to appropriate individuals, including a designated senior physician, and involves a designated behavioral healthcare practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program.* b. *The UM program contains UM strategies, including identification of criteria to be utilized by the plan.* c. *Notification of the MCO's UM strategies, including identification of criteria to be utilized by the plan, is provided to the provider community thirty (30) days prior to implementation or change.* Contract G.3.01	**HSAG Required Evidence:** • Policies and procedures • UM program description • Organizational chart • Job descriptions • Notice of UM criteria to providers **Evidence as Submitted by the MCO:** • IA HCS-364.01 Appropriate Professionals Making UM Decisions Procedure_IA RR page 2 • IA HCS-365.01 Clinical Criteria for UM Decision Making Procedure_IA RR page 4 • a IA HCS 2023 Program Description III.A. Governance. a page 8 • b IA HCS 2023 Program Description V. B. Review Criteria page 36 • c IA HCS 2023 Program Description page 88 • IA_RRQ Attachment 15 UM Org Chart.pptx – entire document • Chief Medical Officer Job Description – entire document • Vice President Healthcare Services Job Description – entire document • Director Healthcare Services Job Description – entire document • Manager Healthcare Services Job Description – entire document • Supervisor UM Care Review Job Description– entire document • UM Nurse CRC Job Description– entire document	☐ Met ☒ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• Provider_Memo_Opioid_Benzo_Initial_Rx_Final508. Entire document. (Sample criteria Notice from Molina IL) • 2022_4th_Quarter_Provider_Newsletter_MHIL_Final508. Page 7 (Sample Newsletter criteria notice from Molina IL)	
MCO Description of Process: Molina Healthcare of Iowa, Inc.'s ("Molina Healthcare of Iowa") UM Program is overseen by our Chief Medical Officer, Dr. Timothy Gutshall in collaboration with our VP of Healthcare Services, VP of BH, Director of BH, and our AVP of LTSS. Molina Healthcare of Iowa follows a hierarchy of criteria, any changes to our criteria will be communicated to our providers 30 days prior to changes taking effect.		
HSAG Findings: Although the MCO demonstrated its PEGA system in the test environment, it had not yet been deployed to the production environment. **Recommendations:** After the site review, the MCO provided its IA State Training Addendum, which the MCO indicated is used to train staff members on Iowa-specific requirements. As specific guidance is received from HHS about contract expectations, the MCO should revise this training document as appropriate to ensure it remains complete and accurate. Additionally, the training document included a dental vendor. As dental benefits are covered primarily by an Iowa prepaid ambulatory health plan (PAHP), the MCO should determine if this delegate is appropriate for the Iowa plan and remove as appropriate.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Provide confirmation that its authorization system, PEGA, is live in the production environment.		
2. *The MCO's UM program description, policies, procedures, and evaluation mechanisms are exclusive to Iowa and do not contain documentation from other state Medicaid programs or product lines operated by the MCO.* a. *The UM program descriptions, policies, procedures, and evaluation mechanisms are annually submitted to HHS for review.* Contract G.3.03	**HSAG Required Evidence:** • Policies and procedures • UM program description • Calendar of deliverables • UM work plan required under Contract G.3.03 **Evidence as Submitted by the MCO:** • IA HCS 2023 Program Description Health Care Services Committee page 9 • IA HCS 2023 Program Description Health Care Services Committee-Workplan/Calendar pages 79-88 o annual HHS review submission, page 83 • IA HCS-325.01 Service Authorization Procedures_IA RR. Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa's UM Program Description, policies and procedures are Iowa specific and will be submitted to HHS annually for review. UM Program Description includes Workplan and Calendar at the end, starting on page 79.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
3. *The MCO's UM program policies and procedures meet all standards of the MCO's accrediting entity and have criteria that:* a. *Are objective and based on medical, behavioral health, and/or long-term care evidence;* b. *Are applied based on individual needs;* c. *Include an assessment of the local delivery system;* d. *Involve appropriate practitioners in developing, adopting, and reviewing them; and* e. *Are annually reviewed and updated as appropriate.* Contract G.3.02	**HSAG Required Evidence:** • Policies and procedures • UM program description **Evidence as Submitted by the MCO:** • IA HCS 2023 Program Description Health Care Services page 37 • a, d, e - IA HCS 365.01 Clinical Criteria for UM Decision making II.B.1-11 Entire document b, c - IA HCS 365.01 Clinical Criteria for UM Decision making II.B.1-11 page 2	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will use federal and state regulations, policies, and benefit guidance as well as nationally accepted evidence-based criteria guidelines for decision making. Review criteria are based on sound medical evidence, updated regularly, and reviewed and approved annually by the HCS Committee. Molina involves practitioners in the development and review of policies when applicable.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
4. *The UM program provides for methods of assuring the appropriateness of inpatient care, analyzing emergency department utilization and diversion efforts, monitoring patient data related to length of stay and re-admissions related to hospitalizations and surgeries, and monitoring provider*	**HSAG Required Evidence:** • Policies and procedures • UM program description • UM program workplan • Plan for monitoring and analyzing utilization data **Evidence as Submitted by the MCO:** • a-IA HCS 2023 Program Description Health Care Services page 9	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
utilization practices and trends for any providers who appear to be operating outside of peer standards. a. *Prior to implementation and upon request by HHS thereafter, the MCO demonstrates the data selection criteria, algorithms, and any additional elements used within the program.* b. *The UM program includes distinct policies and procedures regarding long-term services and supports (LTSS).* Contract G.3.03	• IA HCS 2023 Program Description Health Care Services Workplan/Calendar pages 79-88 • b-IA HCS 2023 Program Description Managed Long Term Services and Supports page 10, 55 and 87 • IA HCS 362.01 Monitoring to Ensure Appropriate Utilization Procedure A-H. pages 1-2 • IA_HCS-507 - Entire document • IA_HCS-507.01 - Entire document • IA_HCS-504 - Entire document • IA_HCS-504.01 - Entire document	
MCO Description of Process: Molina Healthcare of Iowa Healthcare Services (HCS) oversees and monitors its Utilization Management (UM) program to detect and correct potential under and over utilization of services for medical, behavioral health, and LTSS services. Molina will submit any necessary changes to our UM Program Description to HHS upon request and annually for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** The MCO provided documentation that supports that medical utilization reports are produced at least annually and include data from major areas, such as inpatient admissions and days of care; outpatient visits, including emergency department visits; and selected surgical procedures or diagnostic tests. Additionally, the Medical Director and healthcare services staff members reviewed the rates of member complaints about authorizations and referrals received by member services quarterly. The Medical Director and healthcare services staff members will conduct detailed content reviews. These reviews may assess types of utilization problems that are being reported based upon complaint rates that are exceeding established thresholds. Quantitative analysis will also be conducted, including a comparison of plan data for each measure to available comparison information (e.g., CMS) from state or regional Medicaid reports, from published articles about similar populations, or from other affiliated Molina Healthcare of Iowa plans. The MCO also described dashboards that were used to track data. Although the MCO provided sufficient evidence to support reviews and analyses of data were occurring, policies and procedures did not specifically stipulate the thresholds that would prompt a more detailed review. As such, HSAG recommends that the MCO update its policies and/or procedures to outline the specific thresholds that would prompt a review, and any steps that the MCO would take if trends are identified in the data that would support improvement efforts are necessary. This recommendation also applies to the data stipulated under element 5.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
5. *The MCO's UM program is not limited to traditional UM activities, such as prior authorization. The MCO maintains a UM program that integrates with other functional units as appropriate and is supported by the quality management and improvement program.* a. *The UM program has policies, procedures, and systems in place to:* i. *Identify instances of over- and under-utilization of emergency room services and other healthcare services;* ii. *Identify aberrant provider practice patterns (especially related to emergency room, inpatient services, and drug utilization);* iii. *Evaluate efficiency and appropriateness of service delivery;* iv. *Facilitate program management and long-term quality; and* v. *Identify critical quality of care issues.* Contract G.3.04	**HSAG Required Evidence:** • Policies and procedures • UM program description • UM program workplan • Quality assessment and performance improvement (QAPI) program • Organizational chart **Evidence as Submitted by the MCO:** • IA HCS 2023 Program Description Health Care Services page 6-8 • IA HCS 2023 Program Description Health Care Services Committee-Workplan/Calendar pages 87 • IA HCS 362.01 Monitoring to Ensure Appropriate Utilization Procedure A-H. pages 1-2 • IA_RRQ Attachment 15 UM Org Chart.pptx - Entire document • IA_Annual and Five-Year Quality HCS Work Plan Draft, Pg. 82	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa Healthcare Services (HCS) oversees and monitors its Utilization Management (UM) program to detect and correct potential under and over utilization of services for medical, behavioral health, and LTSS services.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
6. *The MCO's UM program links members to the MCO's care coordination program as described in Section G.2 of the Contract. The UM program works in tandem with the MCO's care coordination function to coordinate care transitions, discharge planning, and appropriate follow up care, including but not limited to:* a. *Home health;* b. *Durable medical equipment;* c. *Behavioral health;* d. *Substance use disorder treatment; and* e. *LTSS.* Contract G.3.04	**HSAG Required Evidence:** • Policies and procedures • UM program description • Care coordination program description • UM program workplan • Organizational chart • Staff training materials **Evidence as Submitted by the MCO:** • IA_HCS-107.01 page 2 – Section II. C 1-5 • IA 2023 HCS Program Description, Care Coordination, page 58 • IA 2023 HCS Program Description, Iowa Medicaid Requirement Monitoring: Utilization Management Workplan page 87 • IA_HCS-509.01 - page 1 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • RRQ Attachment 15 UM Org Chart - Entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa facilitates the care coordination for all Molina members to ensure access to benefit coverage and continuity of care and will coordinate with any out of network providers or other MCO's for coordination of discharge planning. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
7. *The MCO has a UM committee directed by the MCO's medical director. The committee is responsible for:* a. *Monitoring providers' requests for rendering healthcare services to its members;* b. *Monitoring the medical appropriateness and necessity of healthcare services provided to its members;* c. *Reviewing the effectiveness of the utilization review process and making changes to the process as needed;* d. *Writing policies and procedures for UM that conform to industry standards including methods, timelines, and individuals responsible for completing each task; and* e. *Confirming the MCO has an effective mechanism in place for a network provider or MCO representative to respond within one (1) hour to all emergency room providers twenty-four (24) hours a day, seven (7) days a week.* Contract G.3.05	**HSAG Required Evidence:** • Policies and procedures • UM program description • UM program workplan • UM committee charter • UM meeting minutes (if any meetings have occurred), or a tentative schedule for upcoming meetings • On-call schedule, or plan to implement an on-call schedule, to respond to emergency room providers **Evidence as Submitted by the MCO:** • a-d IA 2023 HCS Program Description, Healthcare Services Committee page 9-10 • IA HCS 2023 Program Description Health Care Services Committee-Workplan/Calendar page 79-88 • e.IA HCS 2023 Program Description Health Care Services Committee-Workplan/Calendar page 85 • IA HCS-364.01 Appropriate Professionals Making UM Decisions Procedure_IA RR page 2 • UM Nurse and Medical Director On Call Schedule Template 2023 Entire document • IA HCS Committee Charter 2023 Entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina's Healthcare Services Committee meets quarterly and is chaired by the CMO or designated Medical Director. The functions of the committee include review of policies, procedures, utilization review processes, providers requests for member services as well as appropriateness of medical necessity criteria for said services. Prior to and during committee review, identified necessary updates to process/policies/procedures are made as needed. At this time no committee meetings have occurred or are scheduled, so no UM meeting minutes are in evidence		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Coordination With Medicare		
8. *The MCO provides medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare.* a. *The MCO ensures that services covered and provided under the Contract are delivered without charge to members who are dually eligible for Medicare and Medicaid.* b. *The MCO coordinates with Medicare payers, Medicare Advantage Plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also enrolled with Medicare.* c. *The MCO develops a plan to coordinate care for duals and documents such in its Policies and Procedures Manual (PPM).* Contract J.4.10	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims processing guidelines • UM program description • Staff training materials **Evidence as Submitted by the MCO:** • HCS-107 Integration, Coordination, and Access to Care Policy_IA RR, page 1 and 2 • IA_HCS-107.01 Section C. 1-6 (c) page 2 and 4 • IA 2023 HCS Program Description, pg 58 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • IA _Plan_Workflow Coordinate Dual Eligible Care • MHI.CLMS.04 Claims Coordination of Benefits Policy page 2	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa facilitates the care coordination for all Molina members to ensure access to benefit coverage and continuity of care and will coordinate with any out of network providers or other MCO's for coordination of discharge planning. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Coverage		
9. The MCO: a. Identifies, defines, and specifies the amount, duration, and scope of each service that the MCO is required to offer. b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B. c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose. 42 CFR §438.210(a)(1-2) 42 CFR §438.210(a)(3)(i) Contract F.6.01–F.6.04	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Member materials, such as the member handbook and benefits grid • Staff training materials **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description IX page 75 • IA_HCS-107.01 Section C. 5 (c) page 2 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • Iowa Benefit Grid V1.xslx Entire document • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 20	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa authorizes services in accordance with state regulation and covered benefits to ensure each service is sufficient in the amount, duration, and scope to achieve its purpose, this includes physical, behavioral, LTSS, and EPSDT services. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
10. The MCO *has mechanisms in place to ensure that required services are* not arbitrarily denied or reduced in the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. 42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) Contract F.6.05 Contract G.3.01	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.f page 3 • IA 2023 HCS Program Description IX page 75 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • Iowa Benefit Grid V1. Xslx Entire document	☒ Met ☐ Not Met
MCO Description of Process: Services are authorized in accordance with state regulations and covered benefits and are not more restrictive than state guidelines and we do not deny based on diagnosis, illness or condition. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
11. The MCO may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity, or on utilization control procedures, provided that: a. The services furnished can reasonably achieve their purpose. b. The services supporting individuals with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports.	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Coverage guidelines/criteria • Staff training materials **Evidence as Submitted by the MCO:** • a IA HCS-325.01 Service Authorization Procedure II e page 3	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
c. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. 42 CFR §438.210(a)(4) 42 CFR §440.230(d) Contract F.6.06 Contract F.6.09 Contract F.6.12–F.6.13	• IA 2023 HCS Program Description page 43, 56 • b IA_HCS-507 - Page 1 • c IA HCS-325.01 Service Authorization Procedure II d.1.b. page 2 • IA_HCS-504- Entire document • IA_HCS-504.01 – II. E. 1, page 2 • IA_HCS-507.01 - Entire document • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • Iowa Benefit Grid V1.xslx Entire document • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 26 and 88	
MCO Description of Process: Medically necessary services are based on evidence based clinical guidelines to ensure optimum outcomes to achieve their purpose, and any limits placed on benefit provision are in compliance with all state and federal regulations and guidelines. Molina Healthcare of Iowa staff are able to identify any coverage guidelines and limits through our PA matrix and PA look up tool which are configured to align with state coverage requirements. During the review, several other factors are also taken into consideration such as the members Age; comorbidities; Complications; Psychosocial situations; Home Environment, when applicable and availability of any local delivery systems in Molina Healthcare of Iowa's service area as needed to support the patient after hospital discharge (e.g., skilled nursing facilities, sub-acute care facilities, and home care agencies); For individuals who require long term services and supports, coverage guidelines are in place to ensure members receive services and supports which are in alignment with their functional needs and to allow them to remain in the least restrictive setting of their choice. Family Planning- Molina Healthcare of Iowa allows members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina as providing obstetrical and gynecological services, this includes self-directed family planning services and women's health services. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
12. The MCO specifies what constitutes "medically necessary services" in a manner that: a. Is no more restrictive than that used by the Iowa Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. Addresses the extent to which the MCO is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity. iv. The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice. 42 CFR §438.210(a)(5) Contract F.6.24 Contract F.6.28–F.6.31 Contract Exhibit B: Glossary of Terms/Definitions	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS 365.01 Clinical Criteria for UM Decision Making Procedure II.E.2.i-iv page 3 • IA 2023 HCS Program Description, page 4 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • IA_HCS-504 - policy in entirety • IA_HCS-504.01 Entire document • IA_HCS-507 - Entire document • IA_HCS 507.01 Entire document • Provider Manual pg 43 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg 87 and 88	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa provides and authorizes medically necessary services consistent with the person's age, diagnosis, symptomatology and any functional impairments they may have. Services are authorized in accordance with state regulations and covered benefits and are not more restrictive than state guidelines and we do not deny based on diagnosis, illness or condition.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
For individuals who require long term services and supports, coverage guidelines are in place to ensure members receive services and supports which are in alignment with their functional needs and to allow them to remain in the least restrictive setting of their choice. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
13. *Determinations of medical necessity are made on a case-by-case basis and in accordance with the State and Federal laws and regulations.* a. *The MCO does not employ and does not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each member and their medical history.* Contract F.6.07	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Plan to conduct inter-rater reliability (IRR) testing • Staff training materials **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description II.C page 4, 5, 9, 10, and 35 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • IA HCS 366.01 Consistency in Application of Med Nec and IRR.doc - Entire document • Iowa Benefit Grid V1.xslx Entire document • IA_Pharm Med Prior Auth_Addendum, Section III State Variances Reference Table. Policy Citation MHI Pharm 08.1.A Entire document • IA_Oversight of Clinical Reviews_Procedure, Entire document • IA_Pharmacy Training. Slide 8 Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa provides and authorizes medically necessary services consistent with the person's history, age, diagnosis, symptomatology and any functional impairments they may have. Services are authorized in accordance with state regulations and covered benefits, and we do not deny based on diagnosis, illness or condition. To ensure consistent application of criteria for UM decisions, Molina Healthcare of Iowa conducts audits on a monthly, weekly and ad-hoc basis and an annual IRR (or more frequently) is conducted with all clinical staff to audit for compliance of application of criteria. A passing score of 90% must be achieved or a corrective action plan is required. Molina Healthcare of Iowa also has the ability to see real time criteria IRR case studies using our MCG platform. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials, as well as Slide 8 of Pharmacy Training slide for this requirement.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
14. *The MCO develops or adopts UM guidelines to interpret the psychosocial necessity of mental health services and supports. In the context of this requirement, psychosocial necessity is an expansion of the concept of medical necessity and means clinical, rehabilitative, or supportive mental health services that meet all the following conditions:* a. *Are appropriate and necessary to the symptoms, diagnoses, or treatment of a mental health diagnosis;* b. *Are provided for the diagnosis or direct care and treatment of a mental disorder;* c. *Are within standards of good practice for mental health treatment;* d. *Are required to meet the mental health needs of the member and not primarily for the convenience of the member, the provider, or the MCO; and* e. *Are the most appropriate type of service which would reasonably meet the need of the member in the least costly manner.* Contract G.3.08	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Staff training materials **Evidence as Submitted by the MCO:** • IA_2023 HCS Program Description page 39, 40,73, and 81 • IA HCS –365.01 Clinical Criteria for UM Decision Making Procedure II.b.5 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • Iowa Benefit Grid V1.xslx Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: As part of Molina Healthcare of Iowa's standard clinical review process, licensed and trained clinical staff conduct the clinical review of health care service requests for clinical appropriateness (medical necessity and psychosocial necessity) using industry standard behavioral health criteria. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
15. *The determination of psychosocial necessity is made after consideration of:* a. *The member's clinical history including the impact of previous treatment and service interventions;* b. *Services being provided concurrently by other delivery systems;* c. *The potential for services/supports to avert the need for more intensive treatment;* d. *The potential for services/supports to allow the member to maintain functioning improvement attained through previous treatment;* e. *Unique circumstances which may impact the accessibility or appropriateness of particular services for an individual member (e.g., availability of transportation, lack of natural supports including a place to live); and* f. *The member's choice of provider or treatment location.* Contract G.3.08	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Staff training materials **Evidence as Submitted by the MCO:** • IA_2023 HCS Program Description page 40, page 81 • IA HCS – 365.01 Clinical Criteria for UM Decision Making Procedure II.b.5 Entire document • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • Iowa Benefit Grid V1.xslx Entire document	☒ Met ☐ Not Met
MCO Description of Process: As part of Molina Healthcare of Iowa's standard clinical review process, licensed and trained clinical staff conduct the clinical review of health care service requests for clinical appropriateness (medical necessity and psychosocial necessity) using industry standard behavioral health criteria. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
16. *The MCO provides, at minimum, all benefits and services deemed medically necessary services that are covered under the Contract with HHS in accordance with 42 CFR §438.210.* a. *The MCO does not avoid costs for services covered in the Contract by referring members to publicly supported healthcare resources.* b. *The MCO ensures services are provided consistent with the United States Supreme Court's Olmstead decision and shall promote HHS' goal of serving individuals in community integrated settings.* c. *The MCO works collaboratively with Mental Health and Disability Services (MHDS) regions.* Contract F.6.15	**HSAG Required Evidence:** • Policies and procedures • UM program description • Covered benefits grid • Staff training materials • Implementation plan to collaborate with MHDS regions **Evidence as Submitted by the MCO:** • a-c IA 2023 Program Description V.B page 38 • IA HCS-325.01 Service Authorization Procedure II.j.16 page 6 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • Iowa Benefit Grid V1.xslx Entire document • MHDS Region Collaboration Plan Description IA – Entire Document	☒ Met ☐ Not Met
MCO Description of Process: All benefits and services provided are in accordance with 42 CFR §438.210 and Molina does not avoid cost for service by referring members to publicly supported healthcare resources. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
17. *The MCO ensures the provision of covered benefits in accordance with the member's eligibility group as described in Special Contract Exhibit E.* Contract F.6.16–F.6.19	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Special Contract Exhibit E: Covered Benefits	• Covered benefits grid per line of business • Claims processing guidelines • Coverage guidelines/criteria • Staff training materials • HSAG will also use the results of the claims testing scenarios	
	Evidence as Submitted by the MCO: • IA 2023 HCS Program Description IV.B.Care Review Clinician page 19 • IA HCS 325.01 Service Authorization Procedure II.c.1-3 page 1 • IA HCS 364.01 Appropriate Professionals Making UM Decisions, Procedure II.J. page 6 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • Iowa Benefit Grid V1.xslx Entire document • MHI.CLMS.03 Claims Adjudication Policy-Copy.docx Entire document • IA MHIA Claims Iowa Benefits Policy Administration Entire Document • MHI_CIM_BR002_BBRD_Process_Policy Entire document • MHI_CIM_BR002_BBRD_Process_Procedure Entire document • Provider Manual – Benefits and Covered Services pg. 25-33 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 14	

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa's standard prior authorization process includes validating eligibility and benefit verification prior to authorizing medically necessary services. Molina Healthcare of Iowa shall follow and maintain the coverage guidelines/criteria as outlined in our service authorization procedure and Iowa Benefit Grid. Our claims BBRD processing guidelines will outline benefits for the member's eligibility group demonstrated in Iowa Benefit Grid. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
18. *The MCO does not require prior authorization or primary care provider (PCP) referral for the provision of early, periodic, screening, diagnostic, and treatment (EPSDT) services.* Contract F.6.26 Contract G.3.09(f)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual • Covered benefits grid • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS-325.01 Service Authorization Procedure II.J.9 page 5 • IA 2023 HCS Program Description page 71 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • Iowa Benefit Grid V1.xslx Entire document • Provider Manual pg 35 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg 44	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa does not require referral or authorization for EPSDT services. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
19. *The MCO meets the requirements of the Newborn and Mothers Health Protection Act (NMHPA) of 1996.* a. *The MCO does not limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section, unless the attending provider, in consultation with the mother makes the decision to discharge the mother or the newborn child before that time.* b. *The MCO does not require a provider to obtain prior authorization for stays up to the forty-eight (48)- or ninety-six (96)-hour periods.* Contract F.6.27 Contract G.3.09(d)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual • Coverage guidelines/criteria • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS-325.01 Service Authorization Procedure II J.8 page 6 • IA 2023 HCS Program Description page 43 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • Iowa Benefit Grid V1.xslx Entire document • Provider manual pg.57 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg.45	☒ Met ☐ Not Met
MCO Description of Process: In accordance with Newborn and Mothers Health Protection Act (NMHPA) of 1996, Molina Healthcare of Iowa does not require prior authorization of OB delivery stays of up to 48 hours (vaginal), or 96 hours (cesarean section), as captured in the coverage guideline/criteria of our service authorization procedure. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** Although the MCO's policies and procedures stipulated the authorization requirements under the Newborn and Mothers Health Protection Act (NMHPA) of 1996, HSAG recommends that the MCO's provider manual be updated to include information pertaining to the Act for provider awareness.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
20. *The MCO may cover, in addition to services covered under the State Plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder (MH/SUD) benefits in 42 CFR part 438, subpart K and 42 CFR §457.496 (as appropriate to the member).* Contract F.6.32 Contract G.3.16	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual • Coverage guidelines/criteria • Staff training materials **Evidence as Submitted by the MCO:** • HCS-609 BH Mental Health Parity and Addictions Equity Policy_IA RR Entire document • HCS-609.01 BH Mental Health Parity and Addictions Equity Procedure_IA RR Entire document • IA 2023 HCS Program Description page 69 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • Iowa Benefit Grid V1.xslx Entire document • Provider Manual pg.63 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg.4851	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa shall follow and maintain the coverage guidelines/criteria in our mental health and addictions policy and procedure for monitoring for and demonstrating compliance with 42 CFR 438, subpart K and 45 CFR 146.136 regarding the Mental Health Parity and Addiction Equity Act (MHPAEA), including procedures to monitor for and assure parity in the application of quantitative and non-quantitative treatment limits for medical and behavioral health services. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Authorization of Services		
21. The MCO and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services. 42 CFR §438.210(b)(1) Contract G.3.06 Contract G.3.11	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Staff training materials **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description V.E. Pre-Service Requests page 43 and Delegation Oversight page 31 • IA HCS-325.01 Service Authorization Procedure- Entire document • IA_GC-01 Subcontractors Policy page 2 • IA Combined Roles and CRP Detailed Agenda Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 Entire document • IA HCS-504 - policy in entirety • IA HCS-504.01 - policy in entirety • IA_HCS-507 - policy in entirety • IA_HCS-507.01 - policy in entirety • Iowa Benefit Grid V1.xslx	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa and its delegates/subcontractors will follow Molina Healthcare of Iowa's policies and procedures, including all coverage guidelines/criteria for all requests related to medical necessity and appropriateness of all initial and continuing services. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
22. The MCO has in effect mechanisms to ensure consistent application of review criteria for authorization decisions. 42 CFR §438.210(b)(2)(i) Contract G.3.06 Contract G.3.12	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Plan to conduct IRR activities • Staff training materials **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description V. E. page 43 • IA HCS 366.01 Consistency in Application of Medical Necessity Criteria and IRR Doc Guidelines Procedure Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA_HCS-504 - policy in entirety • IA_HCS-504.01 - policy in entirety • IA HCS-507 - policy in entirety • IA HCS-507.01 - policy in entirety • Iowa Benefit Grid V1.xslx	☒ Met ☐ Not Met
MCO Description of Process: To ensure consistent application of criteria for UM decisions, Molina Healthcare of Iowa conducts audits on a monthly, weekly and ad-hoc basis and an annual IRR (or more frequently) is conducted with all clinical staff to audit for compliance of application of coverage guidelines/criteria. This plan to conduct IRR activities is encapsulated in Consistency in Application of Medical Necessity Criteria and IRR Doc Guidelines Procedure. A passing score of 90% must be achieved or a corrective action plan is required. Molina Healthcare of Iowa also has the ability to see real time criteria IRR case studies using our MCG platform. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
23. *The MCO has sufficient staff with clinical expertise and training to interpret and apply the UM criteria and practice guidelines to providers' requests for healthcare or service authorizations for the MCO's members.* Contract G.3.06	**HSAG Required Evidence:** • Policies and procedures • UM program description • UM organizational chart with credentials of staff members • Staff training materials **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description D. Utilization Management Structure Program Description, Work Plan and Committee/Program Structure page 81 • IA HCS 364 Appropriate Professionals Making UM Decisions Policy II page 1 • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA_HCS-504 - policy in entirety • IA_HCS-504.01 - policy in entirety • IA_HCS-507 - page 1 • IA_HCS-507.01 - policy in entirety, especially page 4 C.6 Staffing Requirements and III. Scope • RRQ Attachment 15 UM Org Chart.pptx - Entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa policies require appropriate licensed health professionals to supervise all medical necessity decisions and to have a specific type of personnel responsible for each level of UM decision making. Licensed nurses conduct and approve all services requiring assessment of clinical information and/or the application of all medically necessary criteria. Molina Healthcare of Iowa's Medical Director is responsible for the review of cases regarding medical necessity and/or appropriateness that the HCS staff cannot approve. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
24. The MCO consults with the requesting provider for medical services when appropriate. 42 CFR §438.210(b)(2)(ii) Contract G.3.06 Contract G.3.13	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider materials, such as the provider manual, provider communications • Staff training materials **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description V.E. Pre-Service requests page 43 • IA HCS 371.01 Practitioner Access to Plan Physician Reviewer Procedure II Entire Document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA Provider Manual Redlines 020623 – page 47	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa staff work in collaboration with requesting providers in the event more information is necessary, or to conduct any peer to peer conversations related to the member's care. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
25. *The MCO utilizes the universal prior authorization forms as set forth in Information Letter (IL) 2147-MC-FFS. These forms include:* a. *Outpatient Services (470-5595)* b. *Inpatient Services (470-5594)* c. *Supplemental Form (470-5619)*	**HSAG Required Evidence:** • Policies and procedures • UM program description • Prior authorization forms • Provider materials, such as the provider manual and/or provider contract	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Contract G.3.09(a)	• Staff training materials **Evidence as Submitted by the MCO:** • IA HCS-325.01 Service Authorization Procedure II.J.6 page 5 • IA 2023 HCS Program Description V.A page 35 • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA Provider Manual 020923 - pg.46	
MCO Description of Process: Molina Healthcare of Iowa uses the universal prior authorization forms provided by Iowa HHS. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials. Our Prior Auth forms are also being under development.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
26. *The MCO tracks all prior authorization requests in its information system.* a. *All notes in the MCO's prior authorization tracking system are signed by clinical staff and include the appropriate credentials (e.g., RN, MD, RPh, etc.)* b. *For prior authorization approvals, the MCO provides a prior authorization number to the requesting provider and maintains a record of the following information, at a minimum, in the MCO's information system:* i. *Name and title of caller or submitter;* ii. *Date and time of call, fax, or online submission;* iii. *Prior authorization number;* iv. *Time to determination, from receipt; and* v. *Approval/denial count.*	**HSAG Required Evidence:** • Policies and procedures • UM program description • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS-325.01 Service Authorization Procedure II.J.13-14. a-e page 5 • IA 2023 HCS Program Description V.E. page 43 • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Contract G.3.10(a) Contract K.46	• IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document	
MCO Description of Process: All authorizations requests include signature and credentials of clinical decision-making staff. When an authorization is to approved the requesting provider is given the authorization number and date span of the authorization. Molina Healthcare of Iowa maintains the following information in its authorization UM system a. Name and title of caller or submitter; b. Date and time of call, fax, or online submission; c. Prior authorization number; d. Time to determination, from receipt; and e. Approval/denial count. f. Clinical synopsis inclusive of timeframe of illness or condition, diagnosis, and treatment plan; and g. Clinical guidelines or other rationale supporting the denial (i.e., insufficient documentation). Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
27. *For all denials of prior authorization requests, the MCO maintains a record of the following information, at a minimum, in the MCO's information system:* a. *Name and title of caller or submitter;* b. *Date and time of call or submission;* c. *Clinical synopsis inclusive of time frame of illness or condition, diagnosis, and treatment plan; and* d. *Clinical guidelines or other rationale supporting the denial (i.e., insufficient documentation).* Contract G.3.10(b) Contract K.47	**HSAG Required Evidence:** • Policies and procedures • UM program description • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS-325.01 Service Authorization Procedure II.J.14 page 5 • IA 2023 HCS Program Description V.E. page 43 • IA Combined Roles and CRP Detailed Agenda - Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document	
MCO Description of Process: All authorizations requests include signature and credentials of clinical decision-making staff. When an authorization is to approved the requesting provider is given the authorization number and date span of the authorization. Molina Healthcare of Iowa maintains the following information in its authorization UM system: a. Name and title of caller or submitter; b. Date and time of call, fax, or online submission; c. Prior authorization number; d. Time to determination, from receipt; and e. Approval/denial count. f. Clinical synopsis inclusive of timeframe of illness or condition, diagnosis, and treatment plan; and g. Clinical guidelines or other rationale supporting the denial (i.e., insufficient documentation). Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
28. The MCO authorizes LTSS based on a member's current needs assessment and consistent with the person-centered service plan. 42 CFR §438.210(b)(2)(iii) Contract G.3.14	**HSAG Required Evidence:** • Policies and procedures • Authorization workflow for LTSS • UM program description • Coverage guidelines/criteria • Staff training materials **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description V. A page 35	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• IA 2023 HCS Program Description, Medically Necessary services, page 38 • IA_HCS-507 - Policy, Page 1 • IA_HCS-504.01 - Page 1 • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • Iowa Benefit Grid V1.xslx - Entire document • IA_Clinical Operations High level HCS CM WF - Entire document • IA_Clinical Operations High Level UM WF 2023 Draft - Entire document	
MCO Description of Process: Molina Healthcare of Iowa reviews and authorizes LTSS service determinations based on the assessed needs of the member and ensures alignment with their person-centered service plan. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
29. *The MCO uses appropriate licensed professionals to supervise all medical necessity decisions and specifies the type of personnel responsible for each level of UM, including prior authorization and decision making.* a. *The MCO develops, implements, and adheres to written procedures documenting access to board certified consultants to assist in making medical necessity determinations.*	**HSAG Required Evidence:** • Policies and procedures • UM program description • Job descriptions for UM decision makers • Executed contract with specialty consultant delegate (if applicable) • Organizational chart • Staff training materials	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Contract F.6.08 Contract G.3.07	**Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description IV.A Staffing page 11 • IA 2023 HCS Program Description, Managed Long Term Service and Supports, page 26 • IA HCS 364 Appropriate Professionals Making UM Decisions Policy II page 1 • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • Vice President Healthcare Services Job Description - Entire document • Director Healthcare Services Job Description - Entire document • Manager Healthcare Services Job Description - Entire document Supervisor UM Care Review Job Description - Entire document • UM Nurse CRC Job Description - Entire document • IA_RRQ Attachment 15 UM Org Chart-.pptx - Entire document	
MCO Description of Process: Molina Healthcare of Iowa process is to ensure that qualified licensed health professionals assess clinical information used to support Utilization Management (UM) decisions and utilizes board certified consults as necessary to assist with medical necessity decision making. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials. “Executed contract with specialty consultant delegate” is not applicable.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
30. The MCO ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or LTSS needs. 42 CFR §438.210(b)(3) Contract F.6.08 Contract G.3.07 Contract G.3.15	**HSAG Required Evidence:** • Policies and procedures • UM program description • Job descriptions for UM decision makers • Staff training materials **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description VII.F. page 75 • IA HCS 364 Appropriate Professionals Making UM Decisions Policy_IA RR- page 1 • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • Vice President Healthcare Services Job Description - Entire document • Director Healthcare Services Job Description - Entire document • Manager Healthcare Services Job Description - Entire document • Supervisor UM Care Review Job Description - Entire document • UM Nurse CRC Job Description - Entire document • IA_Pharm Med Prior Auth_Procedure. Section V.D. 9, 10 and 12 • IA_Pharmacist UM JD. Entire document • IA_Pharmacy Training. Slide 8	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa ensures that any decision to deny an item or service authorization request or to authorize an item or service in an amount, duration, or scope that is less than requested amount must be made be made by a health care professional who has appropriate		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
clinical expertise (Medical Director or Pharmacist) in treating the member's medical condition, performing the procedure, or providing the treatment. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Notice of Adverse Benefit Determination		
31. The MCO notifies the requesting provider of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. 42 CFR §438.210(c) Contract H.9.07	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider notice template • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description VII.F page 75 • IA HCS-325.01 Service Authorization Procedure_IA RR page 3 • IA MHIA Medicaid Denial_Draft Iowa Health Link.docx - Entire document • IA MHIA Medicaid Denial_Draft Iowa Hawk I.docx - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA_Pharm Med Prior Auth_Procedure. Section V.I.1&6 • IA_Pharm Med Prior Auth_Addendum V.I Paragraph 2 & 3 page 8-9	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• IA_Pharm_Denial Letter_ENG. - Entire document • IA_Pharm_Denial Letter_SPAN - Entire document • IA_Pharmacy Training. Slide 8.	
MCO Description of Process: Molina Healthcare of Iowa notifies the requesting provider of any decision to deny an item or service authorization request or to authorize an item or service in an amount, duration, or scope that is less than requested amount in writing. Providers are sent a copy of the member letter via fax which includes all appeals information. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
32. The MCO defines an adverse benefit determination (ABD) as: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD. d. The failure to provide services in a timely manner, as defined by HHS. e. The failure of the MCO to act within the time frames provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. f. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization V. Definition's page 8 • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA MHIA Medicaid Denial_Draft Iowa Health Link.docx - Entire document • IA MHIA Medicaid Denial_Draft Iowa Hawk I.docx - Entire document • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg.21 and 85 • IA Provider Manual 020923 pg. 42-43	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.400(b)(1-7) Contract Exhibit B: Glossary of Terms/Definitions	IA_Pharmacy Training. Slide 9	
MCO Description of Process: Molina Healthcare of Iowa's definition of adverse benefit is in alignment with 42 CFR §438.400(b)(1-7) and Iowa contractual requirements. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
33. The MCO gives members written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following: a. The ABD the MCO has made or intends to make. b. The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The member's right to request an appeal of the MCO's ABD, including information on exhausting the MCO's one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.402(b). e. The circumstances under which an appeal process can be expedited and how to request it. f. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with HHS policy,	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template with taglines • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description VII.F page 75 • IA HCS 325.01 Service Authorization V. Definition's page 3 • IA MHIA Medicaid Denial_Draft Iowa Health Link.docx - Entire document • IA MHIA Medicaid Denial_Draft Iowa Hawk I.docx - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA_Pharm Med Prior Auth_Procedure. Section V.I.1&6 • IA_Pharm Med Prior Auth_Addendum V.I Paragraph 2 &3 pages 8-9 • IA_Pharm_Denial Letter_ENG. - Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
under which the member may be required to pay the costs of these services. g. The notice must be consistent with the requirements of 42 CFR §438.10. 42 CFR §438.210(c) 42 CFR §438.404(a)-(b) 42 CFR §438.10 42 CFR §438.402(b)-(c) Contract C.1.01 Contract H.2.01–H.2.06	• IA_Pharm_Denial Letter_SPAN - Entire document • IA_Pharmacy Training. Slide 10	
MCO Description of Process: Any adverse benefit determinations are tailored to member's individual communication needs, barriers, and requirements including language interpretation, aids for low vision and /or deaf /hard of hearing and any regulatory reading level requirements These notifications also include the rationale for the determination in plain terms and cite the utilization criteria or benefit provisions used in making the determination and how the member can obtain a copy at no cost. Denial letters also provide information about the member's appeal rights, continuation of benefit during the appeals process and how to use the appeals process. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** Although the MCO's adverse benefit determination (ABD) notice template generally met all federal requirements, HSAG recommends that the MCO consider updating its template as follows: • Related to sub-element (b), the notice must include the right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits. The MCO's template indicates that "you or your provider can ask for a copy of the rules that were used to make this decision free of charge." The intent of this requirement is that the member can see the documentation the MCO used when making the decision; therefore, HSAG strongly recommends that this language be enhanced to not only include "rules," but also documents, records, and other information. • Related to sub-element (g), the taglines included as part of the ABD notice template did not comply with federal requirements. However, findings related to the taglines will be documented under Standard II. Once the taglines are revised, the MCO must ensure that these taglines are included on all critical member materials, including the ABD notice.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Time Frame for Decisions		
34. For standard authorization decisions, the MCO provides notice as expeditiously as the member's condition requires and within fourteen (14) calendar days following receipt of the request for service. 42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) Contract G.3.09(b) Contract G.3.17 Contract H.3.05	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.j.7 page 5 • IA 2023 HCS Program Description 41 • UMMT TAT MONITORING Presentation Readiness - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will make a decision and notify member and provider within regulatory timeframes. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
35. For cases in which a provider indicates, or the MCO determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. a. *Instances in which a member's health condition shall be deemed to require an expedited authorization decision by the MCO include (for example) requests for home health services and LTSS for members being discharged from a hospital or other inpatient setting when such services are needed to begin upon discharge.* 42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) Contract G.3.09(b) Contract G.3.18	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.j.7 page 5 • a IA HCS 325.01 Service Authorization Procedure II.k page 6 • IA 2023 HCS Program Description 41 • UMMT TAT MONITORING Presentation Readiness - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will make a decision and notify member and provider within regulatory timeframe. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
36. *Ninety-nine (99) percent of standard authorization decisions are rendered within fourteen (14) days of the request for service, or seventy-two (72) hours for expedited authorization decisions. Requests for extensions approved in accordance with the Contract shall be removed from this timeliness measure.*	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Monitoring plan for performance metrics (99 percent) • Staff training materials	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Contract G.3.19	**Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.j.7 page 5 • IA 2023 HCS Program Description 41 • UMMT TAT MONITORING Presentation Readiness - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA HCS-405.01 HCS Monitoring and Oversight Procedure_IA RR-Entire Document	
MCO Description of Process: Molina Healthcare of Iowa will make a decision and notify member and provider within regulatory timeframes. TAT monitoring oversight. Molina has in place reporting and tracking mechanisms to ensure completion of authorizations within regulatory timeframes. This includes real time data monitoring via our authorization system and also includes our UMMT dashboard which include all metrics related to authorizations. Our real time data monitoring allows the staff managing a request and their leadership the ability to see the timeframe for that auth. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
37. *One hundred (100) percent of pharmacy authorization decisions are rendered within twenty-four (24) hours of the request. Requests for extensions approved in accordance with the Contract shall be removed from this timeliness measure.* Contract G.3.19	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Monitoring plan for performance metrics (100 percent) • Staff training materials **Evidence as Submitted by the MCO:** • IA_Pharm Med Prior Auth_Addendum.V.I page 7	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• IA_Oversight of Clinical Reviews_Procedure. Entire document • IA_Oversight of Clinical Reviews_Policy- Entire document • IA_2023 HCS Program Description - Pg 41 • IA_Example_KPI MI 012023 • IA_Pharmacy Training. Slide 12 • IA HCS-405.01 HCS Monitoring and Oversight Procedure_IA RR-Entire Document • IA_UM Pharmacy CAS Queue Management_Monitoring Plan. Entire document • IA_UM Pharmacy Oversight Plan.pptx, entire document	
MCO Description of Process: Molina Healthcare of Iowa will complete 100% of pharmacy authorization decisions within 24 hours of the request. TAT monitoring oversight. Molina has in place reporting and tracking mechanisms to ensure completion of authorizations within regulatory timeframes. This includes real time data monitoring via our authorization system and also includes our UMMT dashboard which include all metrics related to authorizations. Our real time data monitoring allows the staff managing a request and their leadership the ability to see the timeframe for that auth. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
38. For standard and expedited authorization decisions, the MCO may extend the resolution time frame up to an additional fourteen (14) calendar days if: a. The member, or the provider, requests the extension; or b. The MCO justifies a need for additional information and how the extension is in the member's interest. 42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) Contract G.3.09(b) Contract G.3.17 Contract H.3.06–H.3.07 Contract H.3.11	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template • Staff training materials • HSAG also uses the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.k.b page 6 • IA 2023 HCS Program Description 41	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• UMMT TAT MONITORING Presentation Readiness - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA MHIA Extension Letter Hawk I.docx - Entire document • IA MHIA Extension Letter Health Link.docx - Entire document	
MCO Description of Process: All member notifications are provided within the state regulatory timeframes. Member and provider letter are mailed at the time of decision, the provider is also faxed a copy of the decision at the time of the decision. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
39. If the MCO meets the criteria set forth for extending the time frame for standard service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii), it: a. Gives the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision; and b. Issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.404(c)(4)(i-ii) Contract H.3.08–H.3.09	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template(s) • Staff training materials • HSAG also uses the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.k.d. page 6 • IA 2023 HCS Program Description page 41 • UMMT TAT MONITORING Presentation Readiness - Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA MHIA Extension Letter Hawk I.docx - Entire document • IA MHIA Extension Letter Health Link.docx - Entire document	
MCO Description of Process: All member notifications are provided within the state regulatory timeframes. Member and provider letter are mailed at the time of decision, the provider is also faxed a copy of the decision at the time of the decision. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** Although the extension letter template generally complied with federal requirements, HSAG recommends that the MCO consider updating its template as follows: • Under the Decision section of the notice, the MCO indicates that "we may be able to approve the request with the additional details received"; however, the member has not been made aware that needing additional details is the reason for the extension other than within the header of the notice. As such, HSAG recommends that the notice be updated to indicate additional time is needed to obtain medical information from the member's doctor and the notice could then indicate that "we may be able to approve the request with the additional details received." • The notice indicated "we will review it as soon as possible but no later than < seventeen (17) calendar days/ twenty-eight (28) calendar days> from the date of your request." The requirement is that the decision must be made as soon as possible. Therefore, the MCO may consider changing "review" to "make a decision." Also, the expedited review time frame is 72 hours. Therefore, depending on when the MCO receives the authorization request, the decision time frame may be different than 17 calendar days. As such, HSAG recommends that the MCO insert the date in which a decision will be made instead of including the number of days. • Under the Your Rights section, the reason that the member can file a grievance is not clear. The notice should be enhanced to indicate that the member has a right to file a grievance if he or she disagrees with the decision to extend the time frame for making an authorization decision. The language under Grievance Rights should also be reviewed for clarity as it states, "…file a complaint with Molina about issues other than denied claims or services." The intent of this sentence is unclear, especially as it relates to the time frame extension.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
40. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO mails the ABD notice to the member within at least ten (10) days before the date of action, except as permitted under 42 CFR §431.213 and §431.214. 42 CFR §431.211 42 CFR §438.404(c)(1) Contract H.3.01	**HSAG Required Evidence:** • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms • Staff training materials • HSAG also uses the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.k.e page 7 • IA 2023 HCS Program Description page 41 • UMMT TAT MONITORING Presentation Readiness - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA MHIA Medicaid Denial_Draft Iowa Health Link.docx - Entire document • IA MHIA Medicaid Denial_Draft Iowa Hawk I.docx - Entire document	☐ Met ☒ Not Met
MCO Description of Process: All member notifications are provided within the state regulatory timeframes. Member and provider letter are mailed at the time of decision, the provider is also faxed a copy of the decision at the time of the decision. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: After the site review, the MCO provided an updated HCS-325.01 Service Authorization policy indicating the MCO will mail the ABD notice to the member within at least 10 days before the date of action. However, the notice template provided after the site review indicated, "The request from you or your doctor for more of the services below will be <denied> <reduced> <suspended> 10 days from the date of this letter." However, this language implies that the provider submitted a new request for services and that the MCO is not approving all requested services (e.g., partial denial). Termination, suspension, and/or reduction of services requirements apply to previously authorized services that are still in place but the MCO has determined		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
are no longer appropriate or the number of services are no longer medically necessary. Additionally, the notice indicates that "this request for health care services has been reviewed to decide if it is a covered benefit and/or the service is medically necessary. This request has been denied. If you have not yet had these services and you go ahead and get these services, they will not be covered, and you will have to pay for them." This language implies that the services were not already in place.		
Required Actions: In order to receive a *Met* score for this element, the MCO must develop an advanced notice template for terminations, reductions, and suspensions that demonstrate understanding of the termination, reduction, and or suspension of previously authorized services.		
41. The MCO sends a notice not later than the date of action if: a. The MCO has factual information confirming the death of a member; b. The MCO receives a clear written statement signed by a member that: i. He/She no longer wishes services; or ii. Gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information; c. The member has been admitted to an institution where he is ineligible under the plan for further services; d. The member's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address; e. The MCO establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; f. A change in the level of medical care is prescribed by the member's physician; g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or h. The date of action will occur in less than ten (10) days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanisms • Staff training materials • HSAG also uses the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.J.14.h page 5 • IA 2023 HCS Program Description page 41 • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA MHIA Medicaid Denial_Draft Iowa Health Link.docx - Entire document • IA MHIA Medicaid Denial_Draft Iowa Hawk I.docx - Entire document • UMMT TAT MONITORING Presentation Readiness - Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
exceptions to the thirty (30) days notice requirements of §483.15(b)(4)(i). 42 CFR §431.213 Contract H.3.03		
MCO Description of Process: Molina Healthcare of Iowa will issue notice of action per regulatory requirements. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
42. The MCO may shorten the period of advance notice to five (5) days before the date of action if: a. The MCO has facts indicating that action should be taken because of probable fraud by the member; and b. The facts have been verified, if possible, through secondary sources. 42 CFR §431.214 Contract H.3.02	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanisms • Staff training materials • HSAG also uses the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.i.1 • IA 2023 HCS Program Description page 41 • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA MHIA Medicaid Denial_Draft Iowa Health Link.docx - Entire document • IA MHIA Medicaid Denial_Draft Iowa Hawk I.docx - Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• UMMT TAT MONITORING Presentation Readiness - Entire document	
MCO Description of Process: Molina Healthcare of Iowa will issue notice of action per regulatory requirements. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
43. The MCO mails the ABD notice for denial of payment at the time of any action affecting the claim. 42 CFR §438.404(c)(2) Contract H.2.07 Contract H.3.04	**HSAG Required Evidence:** • Policies and procedures • Workflow/guidelines for payment denial on a claim to trigger ABD notice • UM program description • ABD notice template for denial of payment • Tracking and reporting mechanisms • Staff training materials **Evidence as Submitted by the MCO:** • IA MHIA Medicaid Denial_Draft Iowa Health Link.docx - Entire document • IA MHIA Medicaid Denial_Draft Iowa Hawk I.docx - Entire document • IA 2023 HCS Program Description 41 • UMMT TAT MONITORING Presentation Readiness - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• HCS 0743 Notification to Member of Adverse Benefit Determination, page 1	
MCO Description of Process: Molina Healthcare of Iowa mails the notice of ABD for denial of claims at the time of action affecting the claim. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
44. For standard and expedited service authorization decisions not reached within the required time frames specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the MCO provides notice on the date that the time frames expire. 42 CFR §438.404(c)(5) Contract G.3.09(b) Contract H.3.12–H.3.13	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template for untimely determination • Tracking and reporting mechanisms • Staff training materials • HSAG also uses the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.k.g page 7 • IA 2023 HCS Program Description page 41 • ABD Notice template for untimely determination – N/A • IA MHIA Approval Letter Missed Turn Around Time Hawk.I doc.x - Entire document • IA MHIA Approval Letter Missed Turn Around Time Health Link.docx - Entire document • UMMT TAT MONITORING Presentation Readiness - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Per Iowa state regulators, preservice decisions that miss turnaround times are considered an approval. Therefore, there will be no ABD in these circumstances. See HCS 325.01 Service Authorization Procedure. Staff trainings are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. Of note, HHS confirmed that it will be removing the deemed granted language from the contract with a 7/1/23 amendment. In response to this decision, the MCO updated its policies, procedures, and training materials to conform to federal requirements indicating that standard and expedited service authorization decisions not reached within the required time frames specified in 42 CFR §438.210(d) constitute denials and are therefore ABDs, and that notice will be sent to members on the date that the time frame expires.		
Required Actions: None.		
Compensation for Utilization Management Activities		
45. The MCO provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 Contract G.3.21	**HSAG Required Evidence:** • Policies and procedures • UM program description • Listing of UM staff performance standards • Listing of UM department key performance indicators • Staff training materials **Evidence as Submitted by the MCO:** • IA 2023 HCS Program Description III. c page 09 • IA HCS 366.01 Consistency in Application of Medical Necessity Criteria and inter-Rater Reliability Documentation Guidelines - Entire document • UMMT TAT MONITORING Presentation Readiness - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• IA_Oversight of Clinical Reviews_Procedure - Entire document • IA_ Oversight of Clinical Reviews_Policy- Entire document • IA_Pharmacy Training. Slide 8	
MCO Description of Process: Molina Healthcare of Iowa does not use incentive arrangements to reward the restriction of medical care to members and this commitment is regularly communicated to providers, practitioners, members, and Molina staff. Molina has in place reporting and tracking mechanisms to ensure completion of authorizations within regulatory timeframes. This includes real time data monitoring via our authorization system and also includes our UMMT TAT Monitoring dashboard which include all metrics related to authorizations. Our real time data monitoring allows the staff managing a request and their leadership the ability to see the timeframe for that auth. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services						
Met	=	43	X	1	=	43
Not Met	=	2	X	0	=	0
Total	=	45	Total Score		=	43
				Total Score ÷ Total	=	96%

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCO implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. a. *The MCO develops, implements, and adheres to written policies and procedures related to provider credentialing and recredentialing, which include standards of conduct that articulate the MCO's understanding of the requirements and that direct and guide the MCO's and its subcontractors' compliance with all applicable federal and State standards related to provider credentialing, including those required in 42 CFR Parts 438 and 455, Subpart E* [provider screening and enrollment], *which includes the following:* *i. A training plan designed to educate staff in the credentialing and recredentialing requirements.* *ii. Provisions for monitoring and auditing compliance with credentialing standards.* *iii. Provisions for prompt response and corrective action when non-compliance with credentialing standards is detected.* *iv. A description of the types of providers that are credentialed.* *v. Methods of verifying credentialing assertions, including any evidence of prior provider sanctions.* 42 CFR §438.214(a) 42 CFR §438.214(b)(2) 42 CFR §438.214(e) Contract E.3.02-03 Contract E.3.09	**HSAG Required Evidence:** • Policies and procedures • Staff training materials, including training plan • Credentialing monitoring and auditing plan **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Policy Page 2 Section VI(A) • IA _Cred-Recred Practitioner Procedure – Entire Document • IA _Cred-Recred Training Plan - Entire Excel • IA _Cred-Recred Practitioner Procedure Page 34 Section M(1); • IA_System Controls Procedure • IA _Cred-Recred Practitioner Procedure pages 36-37 Section 3(c) • IA _Cred-Recred Practitioner Procedure Pages 6-9 Section D • IA _Cred-Recred Practitioner Procedure Pages 14 – 31 Criteria Grid	☒ Met ☐ Not Met
MCO Description of Process: N/A		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** While MCO staff members explained that they have a team of senior specialists who monitor compliance with the credentialing process and will initiate a corrective action plan (CAP) if a specialist is not meeting standards, HSAG recommends that the MCO clearly document these processes in a procedure, ensure it maintains documentation of these audits, and ensure its auditing processes include any Iowa-specific credentialing requirements.		
Required Actions: None.		
2. The MCO follows a documented process for credentialing and recredentialing of network providers that *meets the guidelines and standards of its accrediting entity* and State requirements for each of the following provider types: a. Acute. b. Primary. c. Behavioral. d. Substance use disorders. e. Long-term services and supports (LTSS) providers. 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) Contract E.3.04-05	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • IA _Assessment and Reassessment of Organizational Providers PROCEDURE - Entire Document • IA _Cred-Recred Practitioner Procedure - Entire Document • IA _Assessment of Organizational Providers Addendum - Entire Document • IA _State Addendum - Entire Document • IA _Cred-Recred Practitioner Policy Page 2 • IA _Assessment and Reassessment of Organizational Providers POLICY Page 2 Section VI(A) • IA _Cred-Recred Training Plan (Tabs CR01 and CR02)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Nondiscrimination		
3. The MCO's network provider selection policies and procedures must not discriminate against particular providers that serve high-	**HSAG Required Evidence:** • Policies and procedures • Nondiscrimination statement for credentialing committee members	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12. 42 CFR §438.214(c) 42 CFR §438.12 Contract E.3.10	• Plan to monitor for discriminatory practices • Staff training materials **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Pages 5 Section C.1. • IA _Cred-Recred Practitioner Policy Page 2 Section VI(B) • IA _Non-Discrimination Report Q3 and Q4 - Entire Document • IA _Nondiscrimination Committee Statement - Entire Document • IA _Cred-Recred Training Plan (Tab CR01)	
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
4. The MCO may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the MCO declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision. b. In all contracts with network providers, the MCO must comply with the requirements specified in 42 CFR §438.214. 42 CFR §438.12(a)(1-2) Contract E.1.06–E.1.08 Contract E.2.01 Contract E.3.01 Contract E.3.19	**HSAG Required Evidence:** • Policies and procedures • Provider notice template(s) for adverse credentialing and/or contracting decisions • Examples of one individual and one organizational executed provider contracts • Nondiscrimination statement for credentialing committee members • Plan to monitor for discriminatory practices • Staff training materials • HSAG will also use the results of the Practitioner and Organizational Credentialing File Review Tools **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Pages 5 Section C.1. • IA_ Cred-Recred Practitioner Policy Page 2 Section VI(B)	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• IA _Denial Letter Template - Entire Document • IA _Intent to Term Template - Entire Document • IA _Nondiscrimination Committee Statement - Entire Document • IA _Non-Discrimination Report Q3 and Q4 - Entire Document • IA _Cred-Recred Training Plan (Tab CR01) • IA - AGMT - PSA - Aaron J Giddings DC - 27-0652628 - Individual • IA - AGMT - PSA - Aase Haugen Homes Inc - 42-0680299 - Skilled Nursing Facility • IA - AGMT - HCBS - Cedar Valley Community Support Services - 30-0007312 - HCBS • IA - AGMT - PSA - Empathy Healthcare LLC - 87-2341670 - Urgent Care	
MCO Description of Process: Molina Healthcare of Iowa has provided Individual and Organizational executed Contracts for Practitioner, Urgent Care, HCBS, and Skilled Nursing Facilities.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Excluded Providers		
5. The MCO may not employ or contract with providers excluded from participation in Federal healthcare programs under either section 1128 or section 1128A of the Social Security Act. a. *The MCO checks employees and subcontractors every month against the Office of Inspector General's (OIG's) List of Excluded Individuals/Entities (LEIE), the General Services*	**HSAG Required Evidence:** • Policies and procedures • Three examples of documentation supporting the screening of employees for sanctions/exclusions • Three examples of documentation supporting the screening of providers for sanctions/exclusions • Plan for ongoing monitoring of sanctions/exclusions	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Administration (GSA) Excluded Parties List System (EPLS), the Social Security Administration Death Master File (SSADMF), the National Plan and Provider Enumeration System (NPPES), and the Iowa Medicaid exclusion list to ensure that no employee or subcontractor has been excluded. b. *The MCO checks the lists of providers currently excluded by the State and the federal government every thirty (30) days. In addition, the MCO checks the SSADMF, the NPPES, the SAM, and the Medicare Exclusion Database (the MED).* 42 CFR §438.214(d)(1) Contract E.3.03 Contract I.1.01–I.1.02 Contract I.2.16	• Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity • Staff training materials • HSAG will also use the results of the Practitioner and Organizational Credentialing File Review Tools **Evidence as Submitted by the MCO:** • IA_4_IA Delegated Services Adden_TMP1, Article Three, 3.1 B.2-6 and 9-11, Page 6 of 26. • IA _Sanctions and Exclusion Examples - Entire Document • IA _Ongoing Monitoring of Sanctions and Exclusions - Entire Document • IA _Cred-Recred Practitioner Procedure Pages 24-25 Section O; Page 15 Section B • IA_OGM – Sanctions Monitoring Procedure - Entire Document • IA_ SSA Death Master File Procedure – Entire Document • IA _Ongoing Monitoring Policy - Entire Document • IA _Cred-Recred Training Plan (Tab CR01) • IA _ Client Workforce-Monitoring_User-Guide_V1-11_2021 • IA_FACIS 3 Monthly Exclusion List Checks • IA_FACIS 3 Scope • IA _Fraud, Waste, and Abuse - General Training 2022 pages 20-21 • IA_HR 6.2 Employment Screening & Licensure • IA _Molina HR Policies Attestation_2023 • IA _ Sterling Workforce Monitoring monthly report sample	
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the MCO review its policy and procedures to ensure they accurately reflect the requirements of this element for all employees, providers, and subcontractors. Additionally, while the MCO crosswalk confirmed that each subcontractor is required to conduct monthly screenings of its employees and providers, as applicable, HSAG recommends that the MCO confirm that its subcontractors (e.g., March Vision, Access2Care) are also included in the MCO's monthly screenings.		
Required Actions: None.		
Contracting		
6. *The MCO establishes written agreements with all network providers. Provider agreements comply with all of the requirements in the Provider Contract Checklist.* Contract E.1.06-E.1.08	**HSAG Required Evidence:** • Policies and procedures • One example each of a provider agreement/contract template for a practitioner, organizational provider, HCBS provider, and a nursing facility • One example each of an executed provider agreement/contract for a practitioner, organizational provider, HCBS provider, and a nursing facility **Evidence as Submitted by the MCO:** • Molina Iowa PSA (FFS) - Provider Contract Template • Molina Iowa HSA (FFS) - Provider Contract Template • Molina Iowa HCBS PSA (FFS) - Provider Contract Template • Executed agreements for Practitioner, Urgent Care, HCBS, and Skilled nursing facility. o IA - AGMT - HCBS - Cedar Valley Community Support Services - 30-0007312 – HCBS o IA - AGMT - PSA - Aaron J Giddings DC - 27-0652628 – Individual o IA - AGMT - PSA - Aase Haugen Homes Inc - 42-0680299 - Skilled Nursing Facility o IA - AGMT - PSA - Empathy Healthcare LLC - 87-2341670 - Urgent Care	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• IA _Assessment and Reassessment of Organizational Providers PROCEDURE page 5 • IA _Cred-Recred Practitioner Procedure page 14 • IA _Aaron J Gidding, DO NPI Registry • IA _Aase Haugen Homes Inc NPI Registry • IA_ Cedar Valley Community Support Services NPI Registry • IA _Empathy Healthcare LLC NPI Registry • IA Contract Templates State Approval Email	
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") has provided sample contract templates for a practitioner via our PSA (Provider Services Agreement), organizational providers, Provider Services Agreement specific to HCBS providers and nursing facility. Molina Healthcare of Iowa has also provided executed agreements for Practitioner, Urgent Care, HCBS, and Skilled nursing facility.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
7. *For the first two (2) years following the MCO's entry into IA Health Link, the MCO gives all of the following providers the opportunity to be part of its provider network:* a. *Community mental health centers (CMHCs);* b. *1915(i) HCBS habilitation services providers;* c. *Nursing facilities;* d. *Intermediate care facilities for the intellectually disabled (ICF/IDs);* e. *Health homes;* f. *1915(c) HCBS waiver providers, with the exception of case managers and care coordinators; and* g. *Substance use disorder treatment programs.* h. *The MCO documents at least three (3) attempts to offer a reasonable rate as part of the contracting process.* Contract E.3.17	**HSAG Required Evidence:** • Policies and procedures • Provider Network Onboarding Plan (as requested via the Questionnaire) • Outreach and contracting plan for provider types in this element • Evidence of communication efforts for each of the provider types in this element • Network adequacy reports • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum pg. 6-7 • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL pg. 1 & 7	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**

	• Evidence of communication efforts for each provider type it this element – requested from Network
	  o IA_CMHC - PLAINS AREA MHC - Contract Question - IA 126
	  o IA_CMHC SOUTHERN IOWA MHC - IA 131
	  o IA_EMAIL 2 Molina Healthcare of Iowa - WEBSTER COUNTY - 35984 – HCBS
	  o IA _ Home Health x SNF Lantis - Molina SNF and HH contract review – 36270
	  o IA_ICF - Tanager Place - Case Management - IA 35285
	  o IA_ICF Molina Healthcare of Iowa - CARE INITIATIVES - IA 26820
	  o IA_SNF x Home Health - IHCQP Contract Follow-Up - IA 36276
	• Network adequacy reports – IA MW2-30 Network Provider Listing Medical Sample provider file
	• Iowa Network Adequacy Reports by Region
	• Staff Training Agenda a.-h.	

MCO Description of Process: Molina continues to offer contracts CMHC's, HCBS, ICF/ID's, 1915(c) waiver providers, SUD treatment programs. We have incorporated this into our Network Accessibility and Adequacy State Addendum, our Provider Network Onboarding Plan, including our network adequacy reporting. For HCBS, we provided email documentation with Webster County as evidence. All documents submitted will be used for staff training purposes.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
8. *For the first six months from the MCO's entry into IA Health Link and for all provider types not described in the Contract section E.3.17, the MCO gives providers the opportunity to be part of its network.*	**HSAG Required Evidence:** • Policies and procedures • Provider Network Onboarding Plan (as requested via the Questionnaire) • Outreach and contracting plan	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
a. *The MCO may use national or multi-state contracts for durable medical equipment or medical supplies.* Contract E.3.18	• Evidence of communication efforts • Network adequacy reports • Staff training materials **Evidence as Submitted by the MCO:** • IA 2022 MHI NSS 1.3a Network Accessibility and Adequacy State Addendum – pages 8 • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL page 1 • Evidence of communication efforts for each provider type it this element – reference Aeroflow email o IA _ Molina Healthcare of Iowa - AEROFLOW INC. DBA AEROFLOW HEALTHCARE - 36279 • IA _ Molina IOWA Cover Letter v08242022 Final	
MCO Description of Process: Molina continues to offer contracts to DME providers. We have incorporated this into our Network Accessibility and Adequacy State Addendum, our Provider Network Onboarding Plan, including our network adequacy reporting. We have submitted email communication relative to outreach and contracting with a DME provider Aeroflow which includes communication, cover letter, contract template, credentialing material, etc. All documents will be used for staff training purposes.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Provider Manual		
9. *The MCO provides and maintains a written program manual for use by the MCO's provider network.* a. *The manual is made available electronically, and in hard copy (upon a provider's request) to all network providers, without cost.* b. *The provider manual includes the requirements in the Provider Manual Checklist.*	**HSAG Required Evidence:** • Policies and procedures • Provider manual • Staff training materials • Link to the provider manual on the MCO's website • HSAG will also use the results of the Provider Manual Checklist	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Contract E.1.03	**Evidence as Submitted by the MCO:** • IA_PS-56 Provider Manual Policy- Entire Document • IA_PS-56 Procedure- Entire Document • IA Provider Manual 020923 – Entire Document • Provider Services employee orientation deck o Iowa Provider Orientation - DRAFT 2023 with Narrative • State Approval of Manual - IA_ "DHS IME MCO Communication _FW_MCO Document Approved (6384 IA Provider Manual Draft)	
MCO Description of Process: Provider Manual is updated at least annually but may be updated more frequently as needed. The initial provider manual draft has been submitted to the state and approved. Additional redlines will be submitted for review as well. Policy and Procedure documents for PS-56 Provider Manual outline the P&P. Providers are notified via blast communication when Provider Manual updates are published to the public website. Internal staff are trained via the internal provider services orientation on the provider manual, and its importance to provider education. P&P documents are also used in internal staff education. PWS link (anticipated go live 4/1): https://www.molinahealthcare.com/providers/ia/medicaid/resources/provider-materials.aspx		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Practitioner Verification of Credentials		
10. *For credentialing and recredentialing, the MCO verifies that the practitioner has a current and valid license to practice within one hundred eighty (180) calendar days of the credentialing decision.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Pages 15-16 Section C • IA _Cred-Recred Training Plan (Tabs CR01 and Practitioner Cred)	☒ Met ☐ Not Met
MCO Description of Process: N/A		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
11. *For credentialing and recredentialing, the MCO verifies that the practitioner has a valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certification, if applicable, prior to the credentialing decision.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Page 18 Section F • IA _Cred-Recred Training Plan (Tabs CR01 and Practitioner Cred)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** HSAG recommends that the MCO ensure that verification of provider registration with the Iowa Board of Pharmacy is included as part of the MCO's ongoing monitoring of its delegates through case file reviews.		
Required Actions: None.		
12. *For credentialing, the MCO verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate prior to the credentialing decision:* a. *Board certification;* b. *Residency; or* c. *Graduation from medical or professional school.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Pages 19-20 Section H • IA _Cred-Recred Training Plan (Tabs CR01 and Practitioner Cred)	☒ Met ☐ Not Met
MCO Description of Process: N/A		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
13. *For credentialing and recredentialing, the MCO verifies the practitioner's board certification status, if applicable, within 180 calendar days of the credentialing decision.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Page 22 Section K • IA _Cred-Recred Training Plan (Tabs CR01 and Practitioner Cred)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
14. *For credentialing, the MCO verifies the practitioner's work history (minimum of the most recent five [5] years of work history) within 365 calendar days of the credentialing decision.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Page 23 Section M • IA _Cred-Recred Training Plan (Tab CR01)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
15. *For credentialing and recredentialing, the MCO verifies a history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Pages 23-24 Section N • IA _Cred-Recred Training Plan (Tabs CR01 and Practitioner Cred)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
16. *For credentialing, when individuals providing services are not required to be licensed, accredited, or certified, the MCO ensures, based on applicable State licensure rules and/or program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.* Contract E.3.06	**HSAG Required Evidence:** • Policies and procedures • List of provider types not required to be licensed, accredited, or certified in the State of Iowa and corresponding required qualifications (e.g., education/training requirements) • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Pages 6 -10 Sections D and E • IA _Assessment and Reassessment of Organizational Providers PROCEDURE Pages 2-4 Section C • IA _Assessment of Organizational Providers Addendum Page 2	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• IA _Cred-Recred Training Plan (Tab IA Addendum)	
MCO Description of Process: Molina Healthcare of Iowa does not have unlicensed provider types that are credentialed at the individual level. Molina credentials the facility the providers are associated with, and the facility is responsible for verifying appropriate education, training, and qualifications of the individual.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** HSAG received clarification from HHS that the member is responsible for training its employees (e.g., Consumer Choices Option [CCO] and Consumer-Directed Attendant Care [CDAC] providers). As such, HSAG recommends that the MCO ensure this expectation is included as part of care management staff training.		
Required Actions: None.		
17. *For credentialing and recredentialing, the MCO ensures that all required criminal history record checks and child and dependent adult abuse background checks are conducted for LTSS providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks. This includes but is not limited to non-agency affiliated self-direction service providers such as Consumer-Directed Attendant Care (CDAC) and Consumer Choices Option (CCO) employees.* a. *Each of the State's 1915(c) HCBS waivers and 1915(i) State Plan HCBS habilitation program, delineate the minimum provider qualifications for each covered service. The MCO ensures all HCBS providers meet these qualifications in accordance with Iowa Administrative Code Chapter 441-77.* Contract E.3.06	**HSAG Required Evidence:** • Policies and procedures • Required qualifications for CDAC and CCO providers • One example each of a completed credentialing file for a CDAC and CCO provider • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool, as applicable **Evidence as Submitted by the MCO:** • IA _Record Check Consent - Entire Document • IA _State Addendum Page 3 • IA _Assessment of Organizational Providers Addendum Page 1; Pages 3-4 • IA_CDAC Medicaid Enrollment - Entire Document • IA _Cred-Recred Training Plan (Tab IA Addendum)	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa is in the process of contracting with Veridian to complete certain functions in the onboarding of CCO Providers. Veridian requires employees to go through background screenings at the time of hire to include Criminal History Records, Sex Offender Registry, and Central Abuse Registry for Child and Dependent Adult Abuse. Employees are also required to go through Medicaid Exclusion checks at the time of hire and monthly thereafter.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Molina Healthcare of Iowa requires individual CDAC providers to be enrolled in Medicaid. Part of the enrollment process requires individuals to complete a Record Check Consent (Form 470-4227). The Record Check Consent Form verifies Sexual Offender Registry, Child Abuse Registry, Dependent Adult Abuse Registry, and Criminal History Records. Molina Contracting verifies Medicaid Enrollment for individual CDAC providers using the Provider Master File (PMF).		
HSAG Findings: The MCO indicated that it is in the process of contracting with Veridian to complete certain functions in the onboarding of CCO providers such as background screenings at the time of hire to include criminal history record checks and child and dependent adult abuse background checks. However, HSAG was unable to verify the contract was executed. After the site review, the MCO indicated the business associate agreement language with Veridian is almost agreed upon and the MCO is awaiting final review from Veridian for it to be executed. The master's service agreement (MSA)/scope of work (SOW) are currently under negotiation. The current SOW states that Veridian will perform the criminal and background checks and is not in dispute, as each party has verbally agreed to that SOW; however, the executed version remains pending.		
Required Actions: In order to receive a *Met* score, the MCO must submit a signed executed contract with Veridian with criminal and background checks, and sanction and exclusion screenings included in the SOW. **Recommendations:** HSAG received clarification from HHS that HHS completes all required criminal history checks and child and dependent abuse background checks. MCO staff members also confirmed that the MCO will verify individual CDAC providers are enrolled with Iowa Medicaid. However, HSAG recommends that the MCO ensure staff training includes comprehensive information on CCO and CDAC. Additionally, HSAG recommends that the MCO clarify with HHS if ongoing background checks are required periodically and, if so, who is responsible for the ongoing background checks (e.g., HHS or the MCO).		
18. *The MCO accepts counselor certification as specified in Iowa Administrative Code r. 6-41-155.21(8) as an acceptable credential for practitioners employed by a licensed substance use disorder treatment program.* Contract E.3.08	**HSAG Required Evidence:** • Policies and procedures • One example of a completed credentialing file for a counselor employed by a licensed substance use disorder treatment program • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tools, as applicable **Evidence as Submitted by the MCO:** • IA _Assessment of Organizational Providers Addendum Page 1	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• IA _Cred-Recred Training Plan (Tab IA Addendum)	
MCO Description of Process: Molina Healthcare of Iowa credentials the facility the practitioners are employed with, and the facility is responsible for accepting counselor certifications as specified in Iowa Administrative Code 641-155.21(8). Molina receives the roster, provided by the facility the counselor is working for. The facility is credentialed and loaded with a PAR contract and a claim will pay for that facility as PAR when the TIN and NPI matches for services provided by the counselor.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Practitioner Sanction Information		
19. *For credentialing and recredentialing, the MCO verifies the State sanctions, restrictions on licensure, and limitations of scope of practice.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA_8 Cred-Recred Practitioner Procedure Pages 16-17 Section D • IA _Cred-Recred Training Plan (Tabs CR01 and Practitioner Cred)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
20. *For credentialing and recredentialing, the MCO verifies the Medicare and Medicaid sanctions.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Pages 24-25 Section O • IA _Cred-Recred Training Plan (Tabs CR01 and Practitioner Cred)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** HSAG recommends that the MCO ensure verification of all required sanction and exclusion screening sources are included in the MCO's ongoing monitoring of its delegates through case file reviews.		
Required Actions: None.		
Practitioner Credentialing Application/Attestation		
21. *For credentialing and recredentialing, the MCO ensures the application and attestation, respectively include:* a. *Reasons for inability to perform the essential functions of the position;* b. *Lack of present illegal drug use;* c. *History of loss of license and felony convictions;* d. *History of loss or limitation of privileges or disciplinary actions;* e. *Current malpractice insurance coverage; and* f. *Current and signed attestation confirming the correctness and completeness of the application.* Contract E.3.06	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Pages 10-11 Section 3(A-G) • IA _Cred-Recred Training Plan (Tab CR01)	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Contract G.7.03		
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Practitioner Ongoing Monitoring		
22. *The MCO implements ongoing monitoring and makes appropriate interventions by:* a. *Collecting and reviewing complaints;* b. *Collecting and reviewing information from identified adverse events; and* c. *Implementing appropriate interventions when it identifies instances of poor quality.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Plan for the collection and monitoring of provider-specific performance issues (e.g., complaints, adverse events, etc.) • Process for implementing interventions **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioner Procedure Pages 43-44 Section 4-5 • IA _Non-Clinical Member Grievance Tracking Proc Signed - Entire Document • IA _Non-Clinical Member Grievance Tracking Policy Signed - Entire Document • IA _Recred Performance Review - Entire Document • IA _Tracking and Trending Member Complaints - Entire Document	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Organizational Verification of Credentials		
23. *For credentialing and recredentialing, the MCO confirms that the provider is in good standing with state and federal regulatory bodies.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • List of organizational provider types and corresponding licensing body in the State of Iowa • HSAG will also use the results of the Organizational Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA_ Assessment and Reassessment of Organizational Providers Procedure Pages 7-8 Section E • IA _Cred-Recred Training Plan (Tabs CR02 and Organizational Cred)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
24. *For credentialing and recredentialing, the MCO confirms that the provider has been reviewed and approved by an accrediting body.* a. *If the provider is not accredited, the MCO conducts an on-site quality assessment.* Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Organizational Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Assessment and Reassessment of Organizational Providers Procedure Pages 5-6 Element C • IA _Cred-Recred Training Plan (Tab CR02)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
25. *For credentialing and recredentialing, the MCO ensures that all facilities, including but not limited to, hospitals are licensed as required by the State.* Contract E.3.07	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Organizational Credentialing File Review Tool **Evidence as Submitted by the MCO:** • IA _Assessment and Reassessment of Organizational Providers Procedure Pages 7-8 Section E • IA _Cred-Recred Training Plan (Tab CR02)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
26. *For credentialing and recredentialing, the MCO ensures that substance use disorder (SUD) treatment services provided to members are provided by programs licensed by Iowa Department of Public Health (IDPH) in accordance with Iowa Code chapter 125 or by hospital-based substance use disorder treatment programs licensed and accredited in accordance with Iowa Code §125.13.2(a).* Contract E.3.08	**HSAG Required Evidence:** • Policies and procedures • One example each of a completed credentialing file for a hospital-based SUD treatment provider and outpatient SUD treatment provider • Staff training materials • HSAG will also use the results of the Organizational Credentialing File Review Tools, as applicable **Evidence as Submitted by the MCO:** • IA _Assessment and Reassessment of Organizational Providers Procedure Pages 7-8 Section E • IA_ Assessment of Organizational Providers Addendum • IA _Cred-Recred Training Plan (Tab IA Addendum)	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa would not separately credential hospital-based SUD treatment providers, these would be included in the hospital's credentialing. There are currently no facility SUD Treatment Providers in process or completed with credentialing.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Time Frames		
27. *The MCO ensures that the credentialing process provides for mandatory recredentialing at a minimum of every three (3) years.* Contract E.3.03 Contract E.3.06 Contract G.7.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Recredentialing timeliness tracking mechanism **Evidence as Submitted by the MCO:** • IA _Cred-Recred Practitioners Procedure Page 40 • IA _Assessment and Reassessment of Organizational Providers Procedure Page 10 Section E(4) • IA _Cred-Recred Training Plan (Tab IA Addendum) • IA _Timeline for Recred Groups - Entire Document	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
28. *The MCO completes credentialing of all providers applying for network provider status as follows:* a. *85 percent within thirty (30) days.* b. *98 percent within forty-five (45) days.* c. *100 percent within sixty (60) days.* *The credentialing performance metric start time begins when the provider submits a formal request to contract and/or participate in the MCO's network. If a provider has not submitted all necessary credentialing materials, the MCO notifies the provider of all additional materials required within seven (7) days from initial receipt of the formal request to contract and/or participate in the network. Completion time starts when all requested materials are received from the provider. Completion time ends when written*	**HSAG Required Evidence:** • Policies and procedures • Reports demonstrating initial credentialing timeliness • Staff training materials • HSAG will also use the results of the Practitioner and Organizational Credentialing File Review Tools **Evidence as Submitted by the MCO:** • IA _State Addendum Page 2 • IA_ Initial Credentialing Timeliness - Entire Document • IA _TAT Calculations - Entire Document • IA _Cred-Recred Training Plan (Tab IA Addendum)	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
communication is mailed, emailed, or faxed to the provider notifying them of the MCO's decision. Contract E.1.29		
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
29. *The MCO completes recredentialing of all contracted providers no less than every three years as follows:* a. *90 percent within 30 days* b. *99 percent within 90 days* Contract E.1.30	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Tracking and reporting mechanisms **Evidence as Submitted by the MCO:** • IA _State Addendum Page 2 • IA _Recred Tracking and Reporting Mechanism - Entire Document • IA _Cred-Recred Training Plan (Tab IA Addendum)	☒ Met ☐ Not Met
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. Of note, HHS clarified that the contract will be updated to indicate that the MCO must complete recredentialing of all contracted Providers no less than every three years.		
Required Actions: None.		

Standard VIII—Provider Selection						
Met	=	28	X	1	=	28
Not Met	=	1	X	0	=	0
Total	=	29	Total Score		=	28
				Total Score ÷ Total	=	97%

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. For medical records and any other health and enrollment information that identifies a particular member, the MCO uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. 42 CFR §438.224 Contract G.2.33	**HSAG Required Evidence:** • Policies and procedures • Disclosure form(s) or other forms used by the MCO to take action regarding member PHI • Staff training materials **Evidence as Submitted by the MCO:** • MHIA HP-03 - Privacy and Confidentiality of PHI; Section II & III • MHIA HP-16 - Confidentiality Information; Section II & III • MHIA Workforce Confidentiality Agreement. • MHIA HP- 44 - Privacy and Security Workforce Training, entire document. • MHIA HP-45 - Sanctioning of Workforce, entire document. • IA Training Overview Document • Training Materials, zip file	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") is compliant with 42 CFR 438.224 and the Iowa Health Link contract as evidenced by the information submitted for this element. All new employees and other workforce members at Molina Healthcare of Iowa must sign the Workforce Confidentiality Agreement at the time of employment and annually thereafter.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
2. *The MCO shall protect and maintain the confidentiality of:* a. *Mental health information by implementing policies for staff and through contract terms with network providers which allow release of mental health information only as allowed by Iowa Code Chapter 228 and Chapter 229.* b. *Substance use disorder information, allowing the release of substance use disorder information only in compliance with*	**HSAG Required Evidence:** • Policies and procedures • Disclosure form(s) or other forms used by the MCO to take action regarding member PHI • Staff training materials **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
policies set forth in 42 CFR Part 2 and Iowa Code Chapter 125.37. c. *Any person upon whom an HIV-related test is performed, or the results of the test which permits identification of the subject of the test and allows the release of HIV-related information only as allowed by Iowa Code Chapter 141A.9.* 42 CFR Part 2 Iowa Code §125.34 Iowa Code §141A.9 Iowa Code §228 Iowa Code §229	• MHIA HP-03 - Privacy and Confidentiality of PHI, Section II, 13-15, pages1-7. • HIPAA Incident Overview Document • Molina Healthcare of Iowa Supplemental HIPAA Training Materials • Training Materials Attachment	
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 Part 2, Iowa Code Chapter 125.34, 141A.9, 228 and 229 as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Uses and Disclosures of PHI		
3. The MCO and its business associates do not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The MCO is permitted to use or disclose PHI as follows: a. To the individual. b. For treatment, payment, or healthcare operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the MCO has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template **Evidence as Submitted by the MCO:** • MHIA HP-03 - Privacy and Confidentiality of PHI; Section III.B.3, Page 3. • MHIA HP 21- Business Associates Contracting; Section III, Pages 1 to 4. • Molina Template Business Associate Agreement, Section 3 & Section 4, Pages 3 to 5. • HIPAA 201-Healthcare Services, Training, Page 4 to 9. • HIPAA Incident Overview Document.	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). 45 CFR §164.502(a)(1)		
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 Part 2, 164.502(a)(1) as evidenced by the information submitted for this element. Molina will track HIPAA Incidents in the Compliance HIPAA Management Program (CHAMP) system.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
4. The MCO has criteria that govern the types of information about members that are safeguarded. This information includes at a minimum: a. Names and addresses; b. Medical services provided; c. Social and economic conditions or circumstances; d. Evaluation of personal information; e. Medical *or psychiatric* data, including diagnosis and past history of disease or disability; f. Any information received for verifying income eligibility and amount of medical assistance payments (see 42 CFR §435.940 through 42 CFR §435.965). Income information received from the Social Security Administration (SSA) or the Internal Revenue Service (IRS) must be safeguarded according to the requirements of the agency that furnished the data, including section 6103 of the Internal Revenue Code, as applicable. g. Any information received in connection with the identification of legally liable third party resources under 42 CFR §433.138. h. Social Security Numbers. 42 CFR §431.305 Iowa Code § 217.30	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template **Evidence as Submitted by the MCO:** • MHIA HP-16-Confidential Information, Section II, III, Pages 1-3 • Molina Template Omnibus Business Associate Agreement, entire document • Molina Healthcare of Iowa Supplemental HIPAA Training Materials	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 431.305 and Iowa Code 217.30 as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
5. The MCO, and its business associates as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the MCO's compliance with CFR 45 §160 subpart C. 45 CFR §164.502(a)(2-4)	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template **Evidence as Submitted by the MCO:** • MHIA HP-03 - Privacy and Confidentiality of PHI; Section III.B. 2.a, Page 3. • MHIA HP 12 - Member's Right to Accounting of Disclosures of PHI, entire document. • MHIA HP 13 - Member's Right of Access to PHI_PII, entire document. • Molina Template Omnibus Business Associate Agreement, Section 4, 4.7, 4.8 & 4.10, Pages 4 & 5. • MHIA HP 21- Business Associates Contracting; Section III, B, Page 2. • HIPAA 101- Privacy Training, Page 9, 10.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 164.502(a)(2-4) as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Minimum Necessary		
6. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the MCO makes reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 CFR §164.502(b)	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • MHIA HP 23- Uses and Disclosures of PHI_PII Minimum Necessary, Section II, A & B, Page 1 & Page 2. • HIPAA 101 HIPAA Privacy Training -New Hire, Pages 9 to 10.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 164.502(b) as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** The MCO's HP 23 Uses and Disclosures of PHI_PII Minimum Necessary policy included the expectation that staff members adhere to the minimum necessary rule when using or disclosing protected health information (PHI). The policy further stated that department management is required to establish protocols for routine disclosures of PHI and/or personally identifiable information (PII) that limit the disclosures to the minimum necessary information. HSAG recommends that the Iowa compliance team and/or the corporate HIPAA Privacy team clearly reiterate this expectation to new management as they are hired for the Molina Healthcare of Iowa plan to ensure that HP 23 requirements, specifically department-specific minimum necessary protocols, are being developed and implemented appropriately and effectively.		
Required Actions: None.		
7. Minimum necessary does not apply to: a. Disclosures to or requests by a healthcare provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law. f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502. 45 CFR §164.502(b)(2)	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • MHIA HP-23- Uses and Disclosures of PHI_PII Minimum Necessary, Section II, B, 1, Page 2. • HIPAA 101 Privacy Training -New Hire, Pages 9 to 10.	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 164.502(b)(2) as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Uses and Disclosures Requiring Authorizations		
8. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI, such use or disclosure is consistent with such authorization. a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity provides the individual with a copy of the signed authorization. 45 CFR §164.508(a)(1) 45 CFR §164.508(b)(1-6) 45 CFR §164.508(c)(1-4)	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Authorization for use and disclosure form **Evidence as Submitted by the MCO:** • MHIA HP 04 - Uses & Disclosures of PHI: Authorization Required, Section II & III, Pages 1 to 6. • IA Request Form Template-Accounting of Disclosures of PHI. • HIPAA 201- Healthcare Services, Page 4-5.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 164.508(a)(1), 164.508(b) (1-6) and 164.508(c)(1-4) as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** Although the MCO's HP 04 Uses and Disclosures of PHI: Authorization Required policy stipulated that members must be provided a copy of the signed authorization when Molina seeks the authorization, HSAG recommends that staff training materials and/or department procedures be updated to clearly reiterate the expectation of providing members with a copy of the signed authorization when the MCO seeks the authorization (e.g., for the release of psychotherapy notes) and inform staff members of the procedures for documenting the delivery of the signed authorization to the member. Additionally, during site review, MCO staff members confirmed that completed Authorization for the Use and Disclosure of PHI forms are effective for 12 months unless the member indicates a different time frame. The 12-month time frame was also consistent with policy. However, the copy of the Authorization for the Use and Disclosure of PHI form provided as evidence for this readiness review indicated a 90-day expiration date. As such, HSAG recommends that the MCO determine the default termination date (i.e., 12 months or 90 days) and ensure that all staff members are using the expiration date field consistently, and that the time frame aligns with Iowa-specific policy requirements.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Discovery of a Breach		
9. The covered entity (i.e., the MCO and its business associates), following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the covered entity to have been, accessed, acquired, used, or disclosed as a result of such breach. a. A breach shall be treated as discovered by a covered entity as of the first day on which such breach is known to the covered entity, or, by exercising reasonable diligence would have been known to the covered entity. b. A covered entity shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent of the covered entity (determined in accordance with the federal common law of agency). 45 CFR §164.404(a) Iowa Code §715C	**HSAG Required Evidence:** • Policies and procedures • Member breach notification templates • Business associate agreement template, including reporting requirements • Staff training materials **Evidence as Submitted by the MCO:** • MHIA HP-39 Privacy Breach Notification, entire document • MHIA HP-39 Privacy Breach Notification, Section II, B, pg. 1 • MHIA HP-39 Privacy Breach Notification, Section III, D, pg. 3 • Molina Template Omnibus Business Associate Agreement • HIPAA 201- Provider Contracting and Services	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 164.404(a)and Iowa Code 715C as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Timeliness of Notification		
10. Except as provided in 45 CFR §164.412 (law enforcement delay), the covered entity provides notification to individuals affected by a breach without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach.	**HSAG Required Evidence:** • Policies and procedures • Timeliness tracking mechanism • Staff training materials	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.404(b) Iowa Code §715C	**Evidence as Submitted by the MCO:** • MHIA HP-39-Privacy Breach Notification, Section III, Section E, 1, a, page 4. • Compliance HIPAA Management System, screen shot • HIPAA 101 HIPAA Privacy Training- New Hire- pages 26 &27	
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 164.404(a)and Iowa Code 715C as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Content of Notification		
11. The notification includes, to the extent possible: a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. b. A description of the types of unsecured protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved). c. Any steps individuals should take to protect themselves from potential harm resulting from the breach. d. A brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches. e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address. 45 CFR §164.404(c) Iowa Code §715C	**HSAG Required Evidence:** • Policies and procedures • Member breach notification template • Staff training materials **Evidence as Submitted by the MCO:** • MHIA HP-39-Privacy Breach Notification, Section III, Section E, 1, b, pg. 4. • HIPAA 101 HIPAA Privacy Training- New Hire, Pages 26 & 27	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 164.404(c) and Iowa Code 715C as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Plain Language		
12. The notification is written in plain language. 45 CFR §164.404(c) Iowa Code §715C	**HSAG Required Evidence:** • Policies and procedures • Member breach notification template • Reading grade level of breach notification template language • Staff training materials **Evidence as Submitted by the MCO:** • MHIA HP-39-Privacy Breach Notification, Section III, Section E, 1, c, pg. 4. • MHIA HP- 39 Privacy Breach Notification, Attachment A, pg. 23 • HIPAA 101 HIPAA Privacy Training- New Hire, Pages 26 &27	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 164.404(c) and Iowa Code 715C as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Written Notification		
13. Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available. a. If the covered entity knows the individual is deceased and has the address of the next of kin or personal representative of the individual (as specified under §164.502(g)(4) of subpart E), written notification by first-class mail to either the next of kin or personal representative of the individual. The notification may be provided in one or more mailings as information is available. 45 CFR §164.404(d) Iowa Code §715C	**HSAG Required Evidence:** • Policies and procedures • Mailing procedures • Staff training materials **Evidence as Submitted by the MCO:** • MHIA HP-39 Privacy Breach Notification, Section III, Section E, 1, d, pg. 5 • HIPAA 101 HIPAA Privacy Training- New Hire -Pages 26&27	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 164.404(d) and Iowa Code 715C as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Substitute Notice		
14. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual under 45 CFR §164.404(d)(1)(i), a substitute form of notice reasonably calculated to reach the individual must be provided. a. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal	**HSAG Required Evidence:** • Policies and procedures • Examples of member breach substitute notices • Staff training materials **Evidence as Submitted by the MCO:** • MHIA HP-39 Privacy Breach Notification, Section III, Section E, 1, d, (iii), pg. 5	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
representative of the individual under 45 CFR §164.404 (d)(1)(ii). b. In the case in which there is insufficient or out-of-date contact information for fewer than ten (10) individuals, then such substitute notice may be provided by an alternative form of written notice, telephone, or other means. c. In the case in which there is insufficient or out-of-date contact information for ten (10) or more individuals, then such substitute notice shall: i. Be in the form of either a conspicuous posting for a period of ninety (90) days on the home page of the Web site of the covered entity involved, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. ii. Include a toll-free phone number that remains active for at least ninety (90) days where an individual can learn whether the individual's unsecured protected health information may be included in the breach. d. In any case deemed by the covered entity to require urgency because of possible imminent misuse of unsecured protected health information, the covered entity may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under 45 CFR §164.404(d)(1). 45 CFR §164.404(d)(2-3) Iowa Code §715C	• MHIA HP-39 Privacy Breach Notification, Attachment A (Ver.1) page 21 (Ver. 2) page 22 • HIPAA 101 HIPAA Privacy Training- New Hire - Pages 26 & 27	
MCO Description of Process: Molina Healthcare of Iowa is compliant with 42 CFR 164.404(d) (2-3) and Iowa Code 715C as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Privacy Rights		
15. The MCO complies with the member's right to request privacy protection for PHI and the requirements under 45 CFR §164.522. 45 CFR §164.522	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Tracking mechanisms (system screenshots are appropriate) • Request form, as available **Evidence as Submitted by the MCO:** • MHIA HP 15 - The Member's Rights to Request Privacy Protections, Section II & III A, Pages 1 & 2 • MHIA PHI Request Workflow 2023 • IA Request Form Template – Special Privacy Protections of PHI, • HIPAA 201 – Member and Provider Contact Center, Page 4 • Compliance HIPAA Management System	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa is compliant with 45 CFR 164.522 as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
16. The MCO complies with the member's right to access PHI and the requirements under 45 CFR §164.524. a. The MCO acts on a request for access no later than thirty (30) days after receipt of the request. b. The MCO provides the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the MCO and member. 45 CFR §164.524	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Tracking mechanisms (system screenshots are appropriate) • Request form, as available **Evidence as Submitted by the MCO:** • MHIA HP 13 -Member's Rights of Access to PHI and PII, Section III, 6, Page 2. • MHIA PHI Request Workflow 2023	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Contract K.25	• Request Form Template – Access to PHI • MHIA HP-13 Member's Rights of Access to PHI and PII, Section III, 6.b, Page 3 • HIPAA 201 – Member and Provider Contact Center, Page 7 • Compliance HIPAA Management System, screenshot	
MCO Description of Process: Molina Healthcare of Iowa is compliant with 45 CFR 164.524 and the Iowa Health Link contract as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
17. The MCO complies with the member's right to have the MCO amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The MCO complies with the requirements under 45 CFR §164.526. a. The MCO acts on the member's request for an amendment no later than sixty (60) days after receipt of such a request. 45 CFR §164.526 Contract K.25	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Tracking mechanisms (system screenshots are appropriate) • Request form, as available **Evidence as Submitted by the MCO:** • MHIA HP 14 - Member's Right to Amend PHI & PII, Section II A, and Section III, 5, Pages 1 and 2 • MHIA PHI Request Workflow 2023 • IA Request Form Template- Amendment of PHI Request. • HIPAA 201 – Healthcare Services, Page 5 • Compliance HIPAA Management System, screenshot	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa is compliant with 45 CFR 164.526 and the Iowa Health Link contract as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
18. The MCO complies with the member's right to receive an accounting of disclosures of PHI made by the MCO in the six (6) years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. a. The MCO acts on the member's request for an accounting, no later than sixty (60) days after receipt of such a request. b. The MCO documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j). 45 CFR §164.528 Contract K.24	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Tracking mechanisms (system screenshots are appropriate) • Request form, as available **Evidence as Submitted by the MCO:** • MHIA HP 12 - Member's Right to Accounting of Disclosures, Section III, C, Page 2 • MHIA PHI Request Workflow • IA Request Form Template- Accounting of Disclosures of PHI, • MHIA HP 12 - Member's Right to Accounting of Disclosures of PHI, Section III, E, Page 3. • HIPAA 201 – Healthcare Services, Page 12 • Compliance HIPAA Management System, screenshot	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa is compliant with 45 CFR 164.528 and the Iowa Health Link contract as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Notice of Privacy Practices		
19. The MCO's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCO, and of the member's rights and the MCO's legal duties with respect to PHI. a. The MCO provides a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii).	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Copy of Notice of Privacy Practices **Evidence as Submitted by the MCO:** • MHIA HP 11 - Notice of Privacy Practices – Provision & Content, Section III, B,1, on Page 2	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
b. The MCO makes the notice available to its members on request as required by 45 CFR §164.520(c)(1-3). 45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1)(i-viii) 45 CFR §164.520(c)(1-3)	• MHIA HP 11 - Notice of Privacy Practices – Provision & Content, Section III, 2 a, on Page 2 • MHIA Medicaid NPP EN, Page 3 • HIPAA 101 HIPAA Privacy Training-New Hire, Page 14	
MCO Description of Process: Molina Healthcare of Iowa is compliant with 45 CFR 164.520(a)(1), 164.520(b)(1)(i-viii) and 164.520(c) (1-3) as evidenced by the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard IX—Confidentiality						
Met	=	19	X	1	=	19
Not Met	=	0	X	0	=	0
Total	=	19	Total Score		=	19
				Total Score ÷ Total	=	100%

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievance System General Requirements		
1. The MCO defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCO to make an authorization decision. 42 CFR §438.400(b) 42 CFR §438.228 Contract Exhibit B: Glossary of Terms/Definitions	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Staff training materials **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP Pg. 1 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg 76 • IA_ Medicaid Grievance Policy pg 2 • IA_Grievance Procedure pg 3	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") defines a grievance as an expression of desertification about any matter other than an Adverse Benefit Determination. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
2. A member may file a grievance with the MCO at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §438.228 Contract H.1.02 Contract H.4.01 Contract H.4.03 Contract H.10.01	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP Pg. 2 • IA_ Authorized Representative Form	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 Pg 76 • IA_Grievance Procedure page 1 and pg 2 • IA_Medicaid Grievance Policy pg 2	
MCO Description of Process: Members may file a Grievance at any time. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
3. The member may file a grievance either orally or in writing *only with the MCO*. 42 CFR §438.402(c)(3)(i) 42 CFR §438.228 Contract H.10.02–H.10.03	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Trainng IA_Standard Grievance SOP Pg. 2 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg 76 • IA_Provider Manual, pg 123 • IA_ Grievance Procedure Addendum: pg 2	☒ Met ☐ Not Met
MCO Description of Process: Members can call the contact center and file a grievance verbally or submit a written grievance. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Handling of Grievances		
4. The MCO acknowledges receipt of each grievance *within three (3) business days.* 42 CFR §438.406(b)(1) 42 CFR §438.228 Contract H.1.06	**HSAG Required Evidence:** • Policies and procedures • Grievance acknowledgment notice template • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP Pg. 2 • IA_Pega Reporting Training • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 Pg 76 • IA_ Mem Grievance Ack ltr • IA_Provider Manual, pg 123 • IA_Grievance Procedure Addendum: pg 1	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa sends Acknowledgement letters within 3 business days of receipt of the grievance. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
5. The MCO ensures that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by HHS, in treating the member's condition or disease: i. A grievance regarding denial of expedited resolution of an appeal.	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of grievance staff members, including credentials • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP Pg. 6 • IA_Medicaid Grievance Policy pg 1	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
ii. A grievance that involves clinical issues. 42 CFR §438.406(b)(2) 42 CFR §438.228 Contract H.1.07 Contract H.1.08(b-c)	• IA_Grievance Procedure pg 2 • IA_AnG Org Chart	
MCO Description of Process: Molina Healthcare of Iowa makes sure that the specialists who review the grievances were not involved in any previous level of review or decision making and the appropriate clinical expertise based on the members condition or disease. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
6. *The MCO directs the following types of grievances to HHS:* a. *Member eligibility including termination of eligibility;* b. *Effective dates of coverage; and* c. *Determinations of premium, copayment, and member participation responsibilities.* Contract H.1.03(a)-(c)	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP pg. 6 • IA_Grievance Procedure Addendum: pg. 2	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will direct all grievances related to the member's eligibility, termination, effective date of coverage and determinations of premiums, copayments and member participation to the state. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** While the MCO confirmed that members will be informed orally and in writing to contact HHS related to the types of grievances specified in this element, HSAG recommends that the MCO update its grievance procedure accordingly and ensure staff members are trained on the oral and written notification process. The MCO should consider developing a specific template that informs the member to contact HHS related to these types of grievances. Additionally, HSAG recommends that the MCO ensure a dropdown menu in its system to categorize these types of grievances when received.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Timely Resolution and Notification of Grievances		
7. The MCO resolves each grievance, and provides notice *in writing*, as expeditiously as the member's health condition requires, within HHS-established time frames that may not exceed the time frames specified in 42 CFR §438.408. a. The MCO resolves the grievance and sends notice to the affected parties *within thirty (30) calendar days* from the day the MCO receives the grievance. 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §438.228 Contract H.10.04 Contract H.10.07	**HSAG Required Evidence:** • Policies and procedures • Grievance resolution notice template • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP pg. 2 • IA_Pega Reporting Training • IA_ Grievance Written Resolution Letter • IA_Grievance Procedure Addendum: pg 1 • IA_Medicaid Grievance Policy pg. 2	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa will send written resolution letters as quickly as the members health conditions requires and not to exceed 30 calendar days from the date the grievance is received. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: The grievance standard operating procedure (SOP) included a first call resolution process in which the case is closed if the grievance was resolved by the contact center and there is no need for follow-up. MCO staff members explained that first call resolutions will still be documented within its system, tracked, and reviewed by the grievance team. However, regardless of whether the member's grievance was resolved during the call with the contact center, the MCO must follow federal and state-specific grievance processing requirements and, therefore, must send a written resolution letter to the member. After the site review, the MCO provided the following narrative: "Molina does and will comply with all requirements, including written notification, on any Grievance - regardless of whether the Grievance was resolved during the initial call or contact from the affected party." However, the MCO did not update its grievance SOP to clearly outline this expectation. The grievance SOP implies that first call resolutions are closed and does not clearly specify that the grievance team would send a grievance resolution letter to the member. Please note, these findings apply to member grievances/expressions of dissatisfaction and not general inquiries received by the contact center.		
Required Actions: In order to receive a *Met* score for this element, the MCO must update its grievance SOP to clarify that a grievance resolution letter will be sent for grievances resolved by the contact center (i.e., first call resolution).		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
8. The MCO may extend the time frame for resolving grievances by up to fourteen (14) calendar days if: a. The member requests the extension; or b. The MCO shows that there is need for additional information and how the delay is in the member's interest, *upon HHS request*. 42 CFR §438.408(c)(1) 42 CFR §438.228 Contract H.10.05	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP pg.5 • IA_Pega Reporting Training • IA_Medicaid Grievance Policy pg. 2 • IA_Grievance Procedure pg. 1	☒ Met ☐ Not Met
MCO Description of Process: The member or Molina Healthcare of Iowa may request a 14-day extension. If Molina Healthcare of Iowa requests the extension, we must show how it is in the member's best interest. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
9. If the MCO extends the grievance resolution time frame not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days gives the member written notice of the reason for the decision to extend the time frame and informs the member of the right to file a grievance if he or she disagrees with that decision. 42 CFR §438.408(c)(2-3) 42 CFR §438.228 Contract H.10.06	**HSAG Required Evidence:** • Policies and procedures • Grievance extension template letter • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP pg.5 • IA_Grievance Ext Letter • IA_Medicaid Grievance Policy pg. 2 • IA_Grievance Procedure pg. 1	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa will make 2 attempts to reach the member by phone and mail a letter withing 2 calendar days of the decision to take an extension. The letter will explain the reason for the delay and provide the member the right to file a grievance if the disagree with the extension. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** The member handbook informed members that they will be notified orally *or* in writing if the MCO extends a grievance resolution time frame. However, the MCO is required to notify the member orally *and* in writing. As such, HSAG recommends the MCO update its member handbook accordingly. The MCO may want to consider simplifying language in the member handbook by informing members that they will be contacted if the MCO applies an extension but not necessarily specify it will be orally and in writing.		
Required Actions: None.		
10. *The MCO resolves one hundred (100) percent of grievances within thirty (30) days of receipt, or within seventy-two (72) hours of receipt for expedited grievances. The MCO maintains a member grievance log documenting compliance with these performance standards.* Contract H.11.04	**HSAG Required Evidence:** • Policies and procedures • Member grievance log template • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP pg. 2 • IA_Pega Reporting Training • IA_Grievance Procedure Addendum: pg. 2 • IA_Member Grievance_Appeal Log Template	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will resolve all grievances within 30 calendar days for standard grievances and 72 hours for expedited grievances. The Member report by case type will show the TAT on all grievances. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Appeals General Requirements		
11. The MCO defines an appeal as a review by the MCO of an ABD. 42 CFR §438.400(b) 42 CFR §438.228 Contract Exhibit B: Glossary of Terms/Definitions	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 1 • IA_ Provider Manual pg. 123 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 76 • IA_Appeals Core Policy pg. 4 • IA Appeals Core Procedure pg. 5	☒ Met ☐ Not Met
MCO Description of Process: An appeal is the review of an Adverse Benefit Determination. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
12. The MCO may have only one (1) level of appeal for members. 42 CFR §438.402(b) 42 CFR §438.228 Contract H.1.04	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 1 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 77 • IA_ Provider Manual pg. 124 • IA_Appeals Core Policy pg. 1	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• IA_ Appeals Core Procedure pg. 3	
MCO Description of Process: Molina Healthcare of Iowa offers only one level of member appeals. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
13. The MCO establishes and maintains an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. a. The MCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. 42 CFR §438.410(a-b) 42 CFR §438.228 Contract E.4.02 Contract H.6.09	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg 3-4 • IA_ Provider Manual pg. 124 & 125 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 77 • IA_Appeals Core Policy pg. 2 • IA_Appeals Core Procedure pg. 2 &3	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has an expedited review process and does not take punitive action against a provider who requests an expedited appeal. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
14. Following receipt of a notification of an ABD by an MCO, the member has sixty (60) calendar days from the date on the ABD notice in which to file a request for an appeal to the MCO. 42 CFR §438.402(c)(2)(ii)	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • Member materials, such as the member handbook • ABD notice template	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 Contract H.5.03 Contract H.5.04	• Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 2 • IA_MCD Denial NABD • IA_Pega Reporting Training • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, pg. 76 • IA_Appeals Core Policy pg. 2 • IA_Appeals Core Procedure pg. 2	
MCO Description of Process: Member appeals must be submitted within 60 calendar days from the date of the adverse benefit determination. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
15. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §438.228 Contract H.1.02 Contract H.4.01 Contract H.4.03 Contract H.6.01–H.6.02	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • Staff training materials **Evidence as Submitted by the MCO:** • IA_Authorized Representative Form • Staff Training IA_Member Appeal SOP pg. 1 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, pg. 77 • IA_Appeals Core Policy pg. 2 • IA_Appeals Core Procedure pg. 2	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa accepts appeals orally or in writing. If the appeal is submitted by an authorized representative the member is required to submit written consent. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** The appeal SOP indicated that two attempts would be made to obtain a signed authorization of representation (AOR) form; however, MCO staff members indicated that all policies were being updated to reflect three attempts. As such, HSAG recommends that the MCO update its appeal SOP accordingly.		
Required Actions: None.		
16. *The MCO does not allow providers, acting on behalf of the member, to pursue an appeal with the MCO or in any way suggest a contracted provider is entitled to a State Fair Hearing when the sole issue in the claimed appeal is a payment dispute between the MCO and the provider, such as whether a given claim is a "clean claim." Such issues are to be addressed pursuant to the dispute resolution process outlined in the agreement between the MCO and the provider.* Contract H.4.04	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and/or provider contract • Staff training materials **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 9 • IA_Provider Manual pg 123 • IA_Appeals Addendum Iowa pg. 2	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa does not allow providers to submit appeals on behalf of the member when the appeal is regarding a payment dispute. The provider is also not allowed to submit a state fair hearing on an appeal submitted on behalf of the member when the sole issue is a payment dispute. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Handling of Appeals		
17. If the MCO denies a request for expedited resolution of an appeal, it: a. Transfers the appeal to the time frame for standard resolution in accordance with 42 CFR §438.408(b)(2). b. Follows the requirements in 42 CFR §438.408(c)(2), including: i. Makes reasonable efforts to give the member prompt oral notice of the delay. ii. Within two (2) calendar days, gives the member written notice of the reason for the decision to extend the time frame and informs the member of the right to file a grievance if the member disagrees with that decision. 42 CFR §438.406(b)(1) 42 CFR §438.410(c) 42 CFR §438.228 Contract H.6.11	**HSAG Required Evidence:** • Policies and procedures • Denied expedited resolution letter template • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 4 & 5 • IA_Expd Appeal Downgrade Letter • IA_Appeals Core Policy pg. 3 • IA_Appeals Core Procedure pg. 3	☒ Met ☐ Not Met
MCO Description of Process: If an appeal does not meet the requirements for an expedited review, it is downgraded to a standard appeal. Molina Healthcare of Iowa will make 2 attempts to reach the member by phone and follow up with a letter within 2 calendar days explaining the reason it has been downgraded and notify the member that they may file a grievance if they don't agree with the 30 calendar day standard appeal resolution timeframe. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
18. The MCO acknowledges receipt of each appeal *within three (3) business days.* a. *The MCO acknowledges one hundred (100) percent of appeals within three (3) business days.* 42 CFR §438.406(b)(1) 42 CFR §438.228	**HSAG Required Evidence:** • Policies and procedures • Appeal acknowledgment template • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Contract H.1.06 Contract H.11.05	**Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 6 • IA_Pega Reporting Training • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, pg. 77 • IA_Member Expedited Appeal Ack Letter • IA_Member pre-service appeal ack letter • IA_Appeals Addendum Iowa pg. 1-2 • IA_Appeals core Policy pg. 1 • IA_Appeals Core Procedure: pg. 1, 2, & 3	
MCO Description of Process: Molina Healthcare of Iowa will acknowledge all standard appeals withing 3 business days of receipt. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** The expedited appeal acknowledgement letter included the following language: "A verbal response will be provided within 72 hours of receipt of the appeal to be followed up in writing." This language suggests that the verbal response must be provided within 72 hours but not necessarily the written response, which is inaccurate. HSAG recommends that the MCO update this language as follows: "A verbal and written response will be provided within 72 hours of receipt of the appeal."		
Required Actions: None.		
19. The MCO ensures that the individuals who made decisions on appeals are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by HHS, in treating the member's condition or disease: i. An appeal of a denial that is based on lack of medical necessity. ii. An appeal that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of appeal staff members, including credentials • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 9 • IA_Ang Org Chart • IA_Appeals Core Policy, pg. 1-2 • IA_ Appeals Core Procedure: pg. 2, 3.	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
representative without regard to whether such information was submitted or considered in the initial ABD. 42 CFR §438.406(b)(2) 42 CFR §438.228 Contract H.1.07–H.1.09		
MCO Description of Process: Molina Healthcare of Iowa ensures that individuals who make the decisions on the appeals were not involved in any previous level or review and are not a subordinate of any such individual, and that they have the appropriate clinical expertise in treating the member's condition or disease. We will take into account all comments, documents, records and other information that was submitted for the appeal without regard to the information that was submitted or considered with the authorization request. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
20. The MCO treats oral inquiries seeking to appeal an ABD as appeals. 42 CFR §438.406(b)(3) 42 CFR §438.228 Contract H.6.04	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 1 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 76 • IA_Appeals Core Policy pg. 2,3 • IA_Appeals Core Procedure pg. 2, 3	☒ Met ☐ Not Met
MCO Description of Process: All oral appeals of an adverse benefit determination are treated as an appeal. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
21. The MCO provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The MCO informs the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. 42 CFR §438.406(b)(4) 42 CFR §438.228 Contract H.6.05 Contract H.6.10	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 9 • IA_ Member Expedited Appeal Ack Letter • IA_Mcd Denl ABD • IA_Appeals Core Policy pg. 2 • IA_Appeals Core Procedure pg. 3	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa notifies the member in the appeal acknowledgment letter of the opportunity in person or writing to present evidence and testimony. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
22. The MCO provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the ABD. a. This information is provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c). 42 CFR §438.406(b)(5) 42 CFR §438.228 Contract H.6.06 Contract H.6.07	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 9 • IA_ Member Expedited Appeal Ack Letter • IA_Mcd Denl ABD • IA_Appeals Core Policy pg. 2	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• IA_Appeals Core Procedure pg. 3	
MCO Description of Process: Members and their authorized representative are provided the case file including the medical records, other documents and records and new or additional evidence considered in connection with the appeal free of charge and in advance of the resolution timeframe of the appeal. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** HSAG recommends that the MCO update its appeal SOP to clarify how staff members will provide an appeal case file to a member sufficiently in advance of the expedited appeal resolution (e.g., portal, overnight mail).		
Required Actions: None.		
23. *The MCO directs appeals about exceptions to policy regarding services outside of State Plan or benefits to HHS.* Contract F.16.09 Contract H.1.03(d)	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP Pg. 2 • IA_ Appeals Addendum Iowa Pg 2	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa directs appeals related to exceptions to policy regarding services outside of the plan or benefits to the State. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Resolution and Notification of Appeals		
24. The MCO resolves standard appeals and sends notice to the affected parties as expeditiously as the member's health condition	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP Pg. 7	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
requires, but no later than thirty (30) calendar days from the day the MCO receives the appeal. a. *The MCO resolves one hundred (100) percent of standard appeals within thirty (30) days of receipt.* 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §438.228 Contract H.7.01 Contract H.11.05	• IA_Appeals Core Policy pg. 2 • IA_Appeals Core Procedure pg. 1 • IA_Appeals Addendum Iowa pg. 2	
MCO Description of Process: Molina Healthcare of Iowa resolves all standard appeals and sends final appeal decision letters as expeditiously as the members condition and no longer than 30 calendar days from the date we receive the appeal. Molina Healthcare of Iowa will resolve 100% of the appeals in 30 days. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
25. The MCO resolves expedited appeals and sends notice to the affected parties no later than seventy-two (72) hours after the MCO receives the appeal. a. *The MCO resolves one hundred (100) percent of expedited appeals within seventy-two (72) hours of receipt.* 42 CFR §438.408(b)(3) 42 CFR §438.228 Contract H.7.04 Contract H.11.05	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg.9 • IA_Appeals Core Policy pg. 3 • IA_Appeals Core Procedure pg. 1, 3 • IA_Appeals Addendum Iowa pg. 1-2	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa resolves all expedited appeals within 72 hours from receipt of the appeal. Molina Healthcare of Iowa will resolve 100% of the expedited appeals within 72 hours. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
26. The MCO may extend the standard or expedited appeal resolution time frames by up to fourteen (14) calendar days if: a. The member requests the extension; or b. The MCO shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.408(c)(1) 42 CFR §438.228 Contract H.7.02 Contract H.7.05	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 6 • IA_Appeals Core Policy pg. 3 • IA_Appeals Core Procedure pg. 1	☐ Met ☒ Not Met
MCO Description of Process: The member may request a 14-day extension. If Molina Healthcare of Iowa requests the extension we will explain why it is in the member's best interest. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG received clarification from HHS that it requires the MCO to seek HHS approval to extend an appeal resolution time frame as the member has additional appeal rights with the State agency. After the site review, the MCO indicated its current appeals policy meets the requirements of this element. Policy language cited by the MCO is as follows: "Molina may extend the timeframe for processing an appeal and expedited appeal by up to fourteen (14) calendar days if the enrollee requests the extension, or if Molina shows that there is need for additional information and that the delay is in the enrollee's interest (upon state request)." However, this language does not clearly state that HHS approval is required for the MCO to extend the appeal resolution time frame.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Submit an updated appeal procedure that specifically indicates the MCO must seek HHS approval of an appeal resolution time frame prior to applying the extension. • Update its staff training and procedure document to include a time frame in which coordinators must seek HHS approval of the extension prior to the 30-day/72-hour due date and the mechanism in which coordinators are to seek approval from HHS (e.g., who at HHS to contact and how).		
27. If the MCO extends the standard or expedited appeal resolution time frames not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay.	**HSAG Required Evidence:** • Policies and procedures • Appeal extension template letter • Staff training materials • HSAG will also use the results of the system demonstration	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
b. Within two (2) calendar days gives the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. c. Resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.408(c)(2) 42 CFR §438.228 Contract H.7.03 Contract H.7.06	**Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 6 & 7 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, pg. 77 • IA_ Member Expedited Extension Request letter • IA_Appeal Extension Letter • IA_Appeals Core Policy pg. 3 • IA_Appeals Core Procedure pg. 1 & 2 • IA_Appeals Addendum Iowa pg. 1	
MCO Description of Process: If Molina Healthcare of Iowa takes an extension on a Standard or Expedited Appeal we will make 2 attempts to reach the member by phone and mail a letter withing 2 calendar days advising how the extension is in the members best interest and how the member may file a grievance if they disagree with the extension. The appeal will be resolved as quickly as possible. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** While the appeal extension letter templates indicated that a need for an independent external review with the same specialty as the provider who requested the appeal as a reason to extend an expedited appeal resolution time frame, HSAG recommends that the MCO ensure this happens in very limited circumstances as the MCO should already be having the appeal reviewed by the appropriate specialist within the 30-calendar day/72-hour time frame. Additionally, the appeal extension letter templates indicated the following as a need to extend an appeal resolution time frame: "You or your physician requested an extension so that additional information could be obtained or considered." While this is accurate, the MCO could also extend the appeal resolution time frame due to the need for additional documentation. As such, HSAG recommends the MCO add as an option to the appeal extension letter templates the need for the MCO to obtain additional documentation or ensure that the template language is revised to indicate the MCO is extending the time frame to obtain additional information rather than indicating the member or provider requested the extension to submit additional information.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
28. In the case that the MCO fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing. 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §438.228 Contract H.5.01	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Member materials, such as the member handbook • Appeal notice template for untimely appeal resolution • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 9 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 77 • IA_Appeal Untimely Resolution • IA_post service denial resolution ltr • IA_pre-service denial resolution ltr • IA_Appeals Core Policy pg. 2 • IA_Appeals Core Procedure pg. 4	☒ Met ☐ Not Met
MCO Description of Process: If Molina Healthcare of Iowa does not complete and notify the member of the appeal decision within 30 calendar days for standard and 72 hours for expedited appeals. Then the appeal is considered to be exhausted and the member may file a State Fair Hearing. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
29. For all appeals, the MCO provides written notice of the appeal resolution that includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a State fair hearing, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request.	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 8	☐ Met ☒ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
iii. That the member may, consistent with *441 IAC 7.17(3)*, be held liable for the cost of those benefits if the hearing decision upholds the MCO's ABD related to the appeal. 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §438.10 42 CFR §438.228 Contract H.8.01	• IA_post service denial resolution ltr • IA_pre-service denial resolution ltr • IA_Appeals Core Policy pg. 3 • IA_Appeals Core Procedure pg. 3-4 • IA_Appeals Addendum Iowa pg. 1	
MCO Description of Process: The appeal denial letter will state the reason for denial, date of denial, the right to request a state fair hearing and how to do so. The letter also advises how the member may request receiving benefits during the hearing and if the hearing upholds Molina Healthcare of Iowa's decision that the member may be responsible for the cost of the services received. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG received clarification from HHS that all addresses for members or providers to return or submit any mail must be located within Iowa. Please note, this finding applies to all member and provider written materials and not just the appeal resolution letter template. This finding aligns with the MCO's contract requirement with HHS to encourage a local presence in Iowa, particularly in relation to the delivery of member and provider services. After the site review, the MCO explained that HHS has requested a plan regarding out-of-state addresses that is due on April 27, 2023. The MCO is working to develop that plan and has already created a post office (PO) box for the receipt of mail related to appeals and grievances. This address has been shared with HHS in the MCO's updated member handbook. **Recommendations:** HSAG recommends that the MCO seek clarification from HHS as to whether HHS expects the reference to 441 IAC 7.17(3) to be included in the member appeal resolution letter template.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Provide an Iowa-based mailing address for members and providers. • Provide confirmation that all member and provider written materials have been updated with the Iowa-based mailing address. • Develop a process to physically obtain mail from the PO box and distribute to the appropriate department timely (HSAG is concerned a possible delay may occur in collecting and subsequently distributing materials to the appropriate department if the MCO does not have a process to regularly collect mail throughout each business day from the PO box versus having mail delivered to a mail room at the MCO's office). • Provide confirmation that HHS has approved the MCO's plan for receiving mail at the MCO's Iowa-based mailing address.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
30. For notice of an expedited appeal resolution, the MCO makes reasonable efforts to provide oral notice. 42 CFR §438.408(d)(2)(ii) 42 CFR §438.228 Contract H.8.02	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 4 • IA_Appeals Addendum Iowa pg. 1	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa will make 2 attempts by phone to notify the member of the decision of the expedited appeal. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
State Fair Hearings		
31. The member may request a State fair hearing only after receiving notice that the MCO is upholding the ABD related to the appeal. 42 CFR §438.408(f)(1)(i) 42 CFR §438.228 Contract H.1.02	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Trainnig IA_Member Appeal SOP pg. 8 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 77 • IA_ pre service appeal denial resolution ltr • IA_ post service appeal denial resolutin ltr • IA_Appeals Core Policy pg. 2 • IA_Appeals Core Procedure pg. 4	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Members may request a state fair hearing only once they have filed an appeal with Molina Healthcare of Iowa and the appeal is denied. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
32. The member has *(120) calendar days* from the date of the MCO's notice of appeal resolution to request a State fair hearing. 42 CFR §438.408(f)(2) 42 CFR §438.228 https://dhs.iowa.gov/	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 8 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 77 • IA_ pre service appeal denial resolution ltr • IA_ post service appeal denial resolution ltr • IA_Appeals Addendum Iowa pg. 1	☒ Met ☐ Not Met
MCO Description of Process: Members have 120 calendar days from the date of Molina Healthcare of Iowa's final Appeal decision letter to file a state fair hearing. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Continuation of Benefits		
33. The MCO continues the member's benefits if all of the following occur: a. The member files the request for an appeal timely (within sixty (60) calendar days from the date on the ABD notice). b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits. *Timely files* means on or before the later of the following: within ten (10) calendar days of the MCO sending the notice of ABD, or the intended effective date of the MCO's proposed ABD. *Note:* This element is not applicable to members under the Hawki program. 42 CFR §438.420(a-b) 42 CFR §438.228 Contract H.9.01–H.9.02	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_COB SOP pg. 2 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 77 • IA_MCD Denial NABD • IA_ pre service appeal denial resolution ltr • IA_Appeals Core Policy pg. 3-4 • IA_Appeals Core Procedure pg. 4	☒ Met ☐ Not Met
MCO Description of Process: For continuation of benefits the member must appeal within 60 calendar days of the Advance Benefit Determination notice, the appeal involves the termination, suspension or reduction of a previously authorized service, the services were ordered by an authorized provider and the authorization timeframe has not expired and the member request the services within 10 calendar days from the ABD or the intended effective date proposed in the ABD letter. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_COB SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
34. If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of following occurs: a. The member withdraws the appeal or request for State fair hearing. b. The member fails to request a State fair hearing and continuation of benefits within ten (10) calendar days after the MCO sends the notice of an adverse resolution to the member's appeal. c. A State fair hearing office issues a hearing decision adverse to the member. *Note:* This element is not applicable to members under the Hawki program. 42 CFR §438.420 (c) 42 CFR §438.228 Contract H.9.03	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_COB SOP pg. 2 • IA_Appeals Core Policy pg. 4 • IA_Appeals Core Procedure pg. 4 • IA_ MCD Denial NABD	☒ Met ☐ Not Met
MCO Description of Process: If the member's request to Molina Healthcare of Iowa continues or reinstates the benefits while the appeal or state fair hearing is pending, the benefits will be continued until the member either withdraws the appeal or request for state fair hearing, the member fails to request a state fair hearing within 10 calendar days after Molina Healthcare of Iowa send a letter upholding the appeal or the state fair hearing office issues a hearing decision that is adverse to the member. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_COB SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
35. If the final resolution of the appeal or state fair hearing is adverse to the member, that is, upholds the MCO's ABD, the MCO may recover the cost of services furnished to the member while the appeal and State fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • Staff training materials	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Note: This element is not applicable to members under the Hawki program. 42 CFR §438.420(d) 42 CFR §438.228 Contract H.9.04	• HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_COB SOP pg. 3 • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 78 • IA_ MCD Denial NABD • IA_ pre service appeal denial resolution ltr • IA_Appeals Core Policy pg. 4 • IA_Appeals Core Procedure pg. 4	
MCO Description of Process: If the final decision of the appeal or state fair hearing is upheld then Molina Healthcare of Iowa may recover the cost of services furnished to the member while the appeal of state fair hearing was pending. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_COB SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
36. If the MCO or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. *Note:* This element is not applicable to members under the Hawki program. 42 CFR §438.424(a) 42 CFR §438.228 Contract H.9.05	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_COB SOP pg. 3 • IA_ Pega Reporting Training • IA_Appeals Core Policy pg. 4 • IA_Appeals Core Procedure pg. 4	☒ Met ☐ Not Met
MCO Description of Process: If Molina Healthcare of Iowa or the state fair hearing overturns the ABD decision to deny, limit or delay services that the member did not receive during the appeal or state fair hearing, Molina Healthcare of Iowa will authorize and provide the services as quickly as possible but		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
no later than 72 hours from the date of the notice approving the services. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_COB SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
37. If the MCO or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO pays for those services, in accordance with HHS policy and regulations. *Note:* This element is not applicable to members under the Hawki program. 42 CFR §438.424(b) 42 CFR §438.228 Contract H.9.06	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_COB SOP pg. 3 • IA_Appeals Core Policy: pg. 4	☒ Met ☐ Not Met
MCO Description of Process: If Molina Healthcare of Iowa or the state fair hearing officer reverses a decision to deny authorization of services that the member received while the appeal was pending, Molina Healthcare of Iowa will pay for the services. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_COB SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Grievances, Appeals, and State Fair Hearings		
38. In handling grievances and appeals, the MCO gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. 42 CFR §438.406(a) 42 CFR §438.228	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Staff training materials **Evidence as Submitted by the MCO:** • Staff Training through Policies and Procedures	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Contract H.1.05	• IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 76 • IA_Appeals Core Policy pg. 1 • IA_Appeals Core Procedure pg. 3	
MCO Description of Process: Molina Healthcare of Iowa provides member seeking an appeal or grievance reasonable assistance in completing the forms and other procedural steps related to the grievance of appeal. This includes but is not limited to auxiliary aids and services upon request such as providing interpreter services and toll free numbers. Molina Healthcare of Iowa Staff training is under development and will include all Policies and Procedures for Appeals and Grievances.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
39. The MCO provides written notice of the grievance and appeal resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. 42 CFR §438.408(d) 42 CFR §438.408(e)(1-2) 42 CFR §438.10 42 CFR §438.228 Contract H.8.01(a) Contract H.10.07	**HSAG Required Evidence:** • Policies and procedures • Mechanisms to assess reading grade level of member notices • Grievance and appeal resolution templates, including taglines • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP pg. 1 • IA_ pre service appeal denial resolution ltr • IA_ post service appeal denial resolution ltr • IA_Grv Written Res Ltr • IA_Appeals Core Policy pg. 3 • IA_Appeals Core Procedure pg. 3-4	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa provides written notice of the grievance and appeal resolution in a format and language that meets 6th grade language. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
40. The MCO provides information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. 42 CFR §438.414 42 CFR §438.228 Contract E.6.01	**HSAG Required Evidence:** • Policies and procedures • Provider manual • Provider contract and subcontractor agreement template **Evidence as Submitted by the MCO:** • IA Provider Manual 020923 Chapter 13-Complaints, Grievances, and Appeals Process pg. 123 - 127 • IA PSA - Provider Services Agreement Template pg. 2 Section 1.1d and pg. 6 Section 2.6 Program Participation	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa provides information on the appeals and grievance system to providers and subcontracts at the time they enter into a contract.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
41. The MCO includes as parties to the appeal and State fair hearing: a. The member and his or her representative b. The legal representative of a deceased member's estate c. For State fair hearings, the MCO. 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §438.228 Contract H.6.08	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and/or notice templates **Evidence as Submitted by the MCO:** • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, pg. 78 • IA_Appeals Core Policy pg. 2 • IA_Appeals Core Procedure pg. 2 & 4	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa allows parties to the appeal and state fair hearing such as the member, his or her representative, the legal representative of a deceased member's estate and for state fair hearings, the MCO.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recordkeeping Requirements		
42. Grievance and appeal records are accurately maintained in a manner accessible to HHS and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. 42 CFR § 438.416(b-c) 42 CFR §438.228 Contract H.11.01–H.11.03	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training through Policies and Procedures • IA_Pega Reporting Training • IA_Medicaid Grievance Policy pg. 2 • IA_Grievance Procedure pg. 2 • IA_Appeals Core Policy pg. 2 • IA_Appeals Core Procedure pg. 4-5 • IA_Appeals Addendum Iowa pg. 2	☒ Met ☐ Not Met
MCO Description of Process: All grievance and appeals are housed and maintained in Pega. It contains the general description of the reason for the appeal or grievance, the date it was received, the date of the review, the resolution of the appeal or grievance, the date of the resolution and the name of the member for whom the appeal or grievance was filed for. Molina Healthcare of Iowa Staff training is under development and will include all Policies and Procedures for Appeals and Grievances.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems						
Met	=	39	X	1	=	39
Not Met	=	3	X	0	=	0
Total	=	42	**Total Score**		=	39
				Total Score ÷ Total	=	93%

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. Notwithstanding any relationship(s) that the MCO may have with any delegate, the MCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with HHS. 42 CFR §438.230(b)(1) Contract J.3.02	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** • IA_4_IA_ Delegated Services Adden_TMP1, Article 1.1, page 1 of 26 • IA_Delegation Oversight Program Policy, Section I. page 1 of 7 • IA_GC-01 Subcontractors Policy, Section II.B, page 1 of 3 • IA_Pharm_Ops_Surveillance_PBM Plan, Paragraph 1, page 1. • IA_Pharm_Ops_Surveillance_Procedure, Section IV page 1 and Section V.A. page 2. • IA_PBM Agreement Covered Plan Joinder o Exhibit B page 4-13	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa, Inc. (“Molina Healthcare of Iowa”) understands notwithstanding any relationships that Molina Healthcare of Iowa may have with any delegate, Molina Healthcare of Iowa understands it has the ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contracts with HHS.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Integrated Subcontracting		
2. *Any subcontracting relationship provides for a seamless experience for members and providers. For example, any subcontracting of claims processing shall be invisible to the provider so as to not result in confusion about where to submit claims for payments.*	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCO:** • IA_Iowa Vendor Addendum 10.20.22, 1.3, page 2 of 11	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Contract J.3.01	• IA Provider Manual 020923, 15. Delegation Section, page 134 • IA_MHC_Member-Handbook_Revised_State-and HSAG_2023 page 3 • IA_GC-01 Subcontractors Policy, Section II.C, page 1 of 3 • IA_Pharm_Ops_Surveillance_Policy Entire document • IA.Pharm_Ops_Surveillance_Procedure , Section V.E. page 2-3 • IA_Pharm_Ops_Surveillance_PBM Plan, Cycle 2 Section. Page 2-3 & Table 3 page 6.	
MCO Description of Process: Molina Healthcare of Iowa, with partnership from its subcontractors, will provide for a seamless experience for members and providers.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Contract or Written Arrangement		
3. *The MCO ensures that Business Associate Agreements are in place as necessary.* Contract J.3.03	**HSAG Required Evidence:** • Policies and procedures • List of all delegated entities requiring Business Associate Agreements and the date the agreement was executed • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • IA_GC-01 Subcontractors Policy, Section II.F, page 2 of 3 • IA_Access2Care LLC Omnibus_BAA, Entire document • IA_MARCH Vision Care Group_BAA, Entire document • IA_Molina Iowa PSA Template, Attachment D, Section 1.3, page 19 of 26 • IA_Master PBM Agreement Exhibit 5. pg 196-201 • IA_Standard XI_Elem.3 Delegated Entities_BAA, Entire document	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa ensures that all subcontractors who require a Business Associate Agreement have the BAA included and executed within the applicable agreements.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
4. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's contract obligations. c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where HHS or the MCO determine that the delegate has not performed satisfactorily. CFR §438.230(c)(1) Contract J.3.04	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • 4.a. IA_4_IA_ Delegated Services Adden_TMP1, Section 1.6 & 1.8 page 3 of 26; Article Three, pages 6 – 19 • 4.b. IA_4_IA_ Delegated Services Adden_TMP1, Section 1.1, page 1 of 26 • 4.c. IA_4_IA_ Delegated Services Adden_TMP1, Article Two, pages 5 – 6 of 26 • IA_Master PBM Agreement., Entire document, but especially o Section 4.6 pg 20 o Section 5.7 pg 23-24 o Section 8.2 Termination, section a, page 41. o Exhibit 2 Implementation and Performance Guarantees: All Lines of Business. Pages 163-181. o Exhibit 2, No 5. page 163 o Exhibit 7, Delegation Services Addendum, Pages 204-213 • IA_PBM Agreement Addendum, o Section A, B,1-B3. Pages 1-2, o Exhibit A pages 4-6 • IA_PBM Agreement Covered Plan Joinder o Sections 1 through 6. Page 4	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa includes the above requirements within delegate agreements.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
5. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. 42 CFR §438.230(c)(2) Contract J.3.06	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • IA_4_IA_ Delegated Services Adden_TMP1, Section 1.10, page 4 of 26 • IA_Molina Iowa PSA Template, Attachment D, Section 1.1, page 19 of 26 • IA_Master PBM Agreement. Section 5.1, page 21 & Section 5.2 page 22 • IA_PBM Agreement Addendum, Section 3a-c, page 1. • IA_PBM Agreement Covered Plan Joinder, Exhibit B Regulatory Requirements. Pages 4-13.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa requires all delegates to comply with Medicaid laws, regulations including applicable subregulatory guidance and contract provisions and codifies this expectation within the delegation agreements.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
6. The contract or written arrangement indicates and the delegate agrees that: a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • IA_4_IA_ Delegated Services Adden_TMP1, Section 1.10.v-viii, page 4 of 26 • IA_Molina Iowa PSA Template, Attachment D, Section 1.12, page 20 of 26	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The delegate agrees that the right to audit will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. 42 CFR §438.230(c)(3) Contract J.3.07–J.3.10	• IA_PBM Agreement Covered Plan Joinder, Sections 10-12. Page 5.	
MCO Description of Process: Molina Healthcare of Iowa includes the above requirements within delegation agreements.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
7. *The MCO requires subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors.* Contract J.3.01	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • IA_GC-01 Subcontractors Policy, Section II.D page 1 of 3 • IA_Molina Iowa PSA Access2Care Working Draft, Attachment C, K.1 page 30 of 70 • IA_March Vision Molina Iowa Working Draft, Attachment C, page 18 of 65 • IA Provider Manual 020923, 15. Delegation Section, page 137 • IA_Master PBM Agreement.docx.	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	○ Section 4.2-Performance Guarantee Standards and Guarantees. Pg 19 ○ Section 4.6-Quality Assurance Activities. Pg 20 ○ Exhibit 2. Implementation and Performance Guarantees: All Lines of Business. Pg 163-181 • IA_PBM Agreement Covered Plan Joinder. Section 31. Pg 9.	
MCO Description of Process: Molina Healthcare of Iowa requires subcontractors who provide direct services to have quality improvement goals and performance management activities specific to the types of services they provide to ensure that they provide the best care and services possible.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Monitoring and Auditing		
8. *Prior to delegation, the MCO evaluates the prospective subcontractor's ability to perform the activities to be delegated, including firm and staff qualifications.* 42 CFR §438.230 Contract J.3.03	**HSAG Required Evidence:** • Policies and procedures • Pre-delegation audit tool template • Staff training materials • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • IA_4_IA_ Delegated Services Adden_TMP1, Section 1.3, page 2 of 26 • IA_Delegation Oversight Program Policy, Section II, B.1., page 2 of 7 • IA_Delegation Oversight_Proced, Section II.I.A-C page 2 of 6 • IA_2022 Pre-Del Cred Audit - CHI Health Notice, Entire document • IA_CHI_2023 Preassessment Audit Summary, Entire document • IA_Cred Audit Tool_Example, Entire tool • IA_GC-01 Subcontractors Policy, Section II.E, page 1 of 3	☐ Met ☒ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• IA_IA Contract Req Staff Training – DO, Entire document • IA_Pharm_Ops_Surveillance_Procedure, Section V.D. page 2. • IA_2023 Pre-Delegation Audit_CVS_Caremark Notice, Entire document. • IA_Pharm_Ops_Surveillance_PBM Plan, Section: Cycle 1, page 3 & Table 2 page 5-6. • IA_Pharmacy Training. Slides 13-19	
MCO Description of Process: Molina Healthcare of Iowa conducts pre-delegation audits/reviews for all prospective delegates testing and validating that they can perform the activities they are delegated to perform.		
HSAG Findings: The IA_4_IA_ Delegated Services Adden_TMP1 policy addendum identified that prior to delegating functions, the MCO would conduct a comprehensive pre-delegation assessment of the provider's ability and administrative capabilities to perform each delegated function. One of the three delegate files reviewed did not include the pre-delegation assessment. In follow-up to the site review, MCO staff members indicated that the MCO was still in the process of completing the pre-delegation assessment.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Provide the completed pre-delegation assessment for CVS Caremark. • Provide written confirmation when the MCO has completed all Iowa Medicaid managed care subcontractors' pre-delegation assessments.		
9. *The MCO has policies and procedures to audit and monitor subcontractors' data, data submission and performance, and implements oversight mechanisms to monitor performance and compliance with Contract requirements.* 42 CFR §438.230 Contract J.3.05	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • IA_Delegation Oversight Program Policy, Section II, B.3., page 3-4 of 7 • IA_Delegation Oversight_Proced, Section II.I.C.1 page 2 of 6, Section III.. pages 2-4 of 6 • IA_GC-01 Subcontractors Policy, Section II.J. page 2 of 3 • IA_Report Monitoring_SOP, Entire SOP • IA_IA Contract Req Staff Training – DO, Entire document • IA_Pharm_Ops_Surveillance_Policy, Entire document.	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• IA_Pharm_Ops_Surveillance_Procedure, Entire document • IA_Pharm_Ops_Surveillance_Addendum, Entire document. • IA_Pharm_Ops_Surveillance_PBM Plan, Entire document. • IA_Master PBM Agreement, Exhibit 2. Implementation and Performance Guarantees: All Lines of Business. Pg 163-181 • IA_Pharmacy Training, Slides 13-19	
MCO Description of Process: Molina Healthcare of Iowa has extensive policies and procedures detailing how it audits and monitors subcontractors' data, data submission and performance, and implements oversight mechanisms to monitor performance and compliance with Contract requirements		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
10. *The MCO monitors the subcontractor's performance on an ongoing basis.* a. *Formal reviews are conducted by the MCO at least quarterly.* b. *Whenever deficiencies or areas of improvement are identified, the MCO and subcontractor take corrective action.* c. *The MCO provides to HHS the findings of all subcontractor performance monitoring and reviews upon request and notifies HHS any time a subcontractor is placed on corrective action.* 42 CFR §438.230 Contract J.3.05	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will use the data from the Delegation Universe File • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • IA_4_IA_ Delegated Services Adden_TMP1, Section 1.4, page 2-3 of 26; Section 2.1, page 5 of 26 • IA_Delegation Oversight Program Policy, Section II, B.3., page 3-4 of 7 • IA_Delegation Oversight_Proced, Section III.B. pages 2-3 of 6 • IA_Delegation Oversight CAP_Proced, Entire document • IA_GC-01 Subcontractors Policy, Section II.K. page 2 of 3 • IA_IA Contract Req Staff Training – DO, Entire document • IA_Access2Care and MHIs JOC Agenda Iowa • IA_MVC and MHIs JOC Agenda Iowa • IA_GC-01 Subcontractors Policy, Section II.L page 2 of 3	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**

	• IA_Pharm_Ops_Surveillance_Policy, Entire document.
	• IA_Pharm_Ops_Surveillance_Procedure, Entire document
	• IA-Pharm_Ops_Surveillance_Addendum, Entire document.
	• IA_Pharm_Ops_Surveillance_PBM Plan, Entire document.
	• IA_Master PBM Agreement.docx.
	  o Section 4.6-Quality Assurance Activities. Pg 20
	  o Section 5.7-Corrective Action Plans. Pg 23-24.
	  o Exhibit 2. Implementation and Performance Guarantees: All Lines of Business. Pg 163-181
	• IA_PBM Agreement Covered Plan Joinder, Section 8. Pg 5
	• IA_EXAMPLE_PBM Surveillance Summary_AZ_2022 Entire document.	

MCO Description of Process: Molina Healthcare of Iowa has extensive processes to provide ongoing monitoring of the delegate performance. When deficiencies are identified, Molina Healthcare of Iowa swiftly issues corrective action to remediate and mitigate non-compliance. Molina Healthcare of Iowa will provide HHS the findings of all subcontractor performance monitoring and reviews upon request and will notify HHS any time a subcontractor is placed on corrective action		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Additional State Requirements		
11. *The MCO notifies HHS in writing of all subcontracts relating to deliverables to be provided under its Contract prior to the time the subcontract(s) become effective.* 42 CFR §438.230 Contract J.3.03	**HSAG Required Evidence:** • Policies and procedures • Copies of the notification to HHS of subcontractors responsible for deliverables **Evidence as Submitted by the MCO:** • IA_GC-01 Subcontractors Policy, Section II.G page 2 of 3 • IA_HHS Material Submission 891 PBM Contractia • IA_Molina_Subcontractor_list_2-16-23 Entire document.	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• IA_HHS Subcontract Notification 2-16-23 Entire excel list document.	
MCO Description of Process: Molina Healthcare of Iowa notifies HHS in writing of all subcontracts relating to deliverables to be provided under its Contract prior to the time the subcontract(s) as documented in Molina's Healthcare of Iowa's subcontractor policy. Molina Healthcare of Iowa notifies HHS of subcontracts prior to becoming effective.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
12. *The MCO submits for HHS review and approval subcontractor agreements for any subcontractor whose payments are equal to or greater than five (5) percent of capitation payments under the Contract.* a. *HHS reserves the right to review and approve any subcontracts, and all subcontracts are accessible to HHS and provided within three (3) business days of request.* 42 CFR §438.230 Contract J.3.03	**HSAG Required Evidence:** • Policies and procedures • List of Delegates who will potentially meet the 5 percent or greater capitation payment threshold • Notification to HHS of subcontractors whose payments are equal to or greater than five (5) percent of capitation **Evidence as Submitted by the MCO:** • IA_GC-01 Subcontractors Policy, Section II.H page 2 of 3 • IA_List of Delegates Potential Five Percent Capitation Entire Document • IA_HHS_Notification 5 Percent Capitation Entire document.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa understands and acknowledges its responsibility to submit for HHS review and approval subcontractor agreements for any subcontractor whose payments are equal to or greater than five (5) percent of capitation payments under the Contract, as documented in Molina Healthcare of Iowa's subcontractor policy. Based on Molina Healthcare of Iowa's most recent review, we project that our CVS Caremark contract will likely exceed 5% of capitation payments and have notified HHS of this projection. Outside of CVS, Molina Healthcare of Iowa confirms we do not have other subcontracts that are expected to be worth at least 5% of capitation payments under the contract at this time.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation						
Met	=	11	X	1	=	11
Not Met	=	1	X	0	=	0
Total	=	12	Total Score		=	11
				Total Score ÷ Total	=	92%

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. The MCO adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. 42 CFR §438.236 (b)(1) Contract G.4.01	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines specific to Iowa • Iowa-specific meeting minutes documenting committee review/approval, and/or planned meeting schedule and agenda **Evidence as Submitted by the MCO:** • IA_CPG PHG Draft Procedure – page 2, section IIA, page 3, section IIB, section IIC, page 4 • IA_CPG PHG Draft Policy – entire document • IA_QIC_Agenda_Q42023 – See Section "New Business" for agenda items • IA_Provider Manual 020923, page 78-79	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa Inc. ("Molina Healthcare of Iowa") has processes in place to adopt practice guidelines that are based on valid clinical evidence and/or consensus of experienced providers.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
2. The MCO adopts practice guidelines that consider the needs of the MCO's members. 42 CFR §438.236 (b)(2) Contract G.4.02	**HSAG Required Evidence:** • Policies and procedures • Analysis of the needs of the MCO's membership (i.e., using Iowa demographics and/or other published data) • List of adopted practice guidelines specific to Iowa • Iowa-specific meeting minutes documenting committee review/approval, and/or planned meeting schedule and agenda **Evidence as Submitted by the MCO:** • IA_CPG PHG Draft Policy – pg. 1 Section I. and pg. 2 Section II.C. and Section II.G.	☒ Met ☐ Not Met

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• IA_CPG PHG Draft Procedure – page 2, section IIA, page 2, section 3 • IA_Provider Manual 020923, page 78-79 • IA_QIC_Agenda_Q42023 – See Section "New Business" for agenda items	
MCO Description of Process: Molina Healthcare of Iowa considers the needs of its members in the adoption of practice guidelines.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
3. The MCO adopts practice guidelines that are adopted in consultation with network providers. 42 CFR §438.236 (b)(3) Contract G.4.03	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines specific to Iowa • Iowa-specific meeting minutes documenting committee review/approval, and/or planned meeting schedule and agenda • Evidence of consultation of network providers	☒ Met ☐ Not Met
	Evidence as Submitted by the MCO: • IA_CPG PHG Draft Policy, entire document • IA_CPG PHG Draft Procedure – page 4, section IIC • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pg. 100 • IA_Provider Manual 020923, page 78-79 • IA_QIC_Agenda_Q42023 – See Section "New Business" for agenda items	
MCO Description of Process: Molina Healthcare of Iowa consults with network providers in adoption of practice guidelines. For evidence of consultation of network providers: Once Molina begins operation in Iowa, Molina will adopt practice guidelines with the consultation of network providers during QMQI Committee meetings when the guidelines are reviewed for approval. During these committee meetings, Molina will ask network providers if there are any additional guidelines that should be adopted to meet the needs of health plan members. The sample meeting agenda is being attached for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends the MCO consider adding to the IA_CPG PHG Draft Procedure the provider feedback loop in regard to clinical practice guidelines (CPGs). Additionally, the MCO should ensure that the local quality improvement committee meeting minutes are written in detail and thoroughly document the discussion that occurs amongst providers when reviewing CPGs and the process for adopting the CPGs.		
Required Actions: None.		
4. The MCO adopts practice guidelines that are reviewed and updated periodically as appropriate. 42 CFR §438.236 (b)(4) Contract G.4.04	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** • IA_CPG PHG Draft Procedure – Section IIC, page 4.	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa reviews and updates practice guidelines as appropriate.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Dissemination of Guidelines		
5. The MCO disseminates the guidelines to: a. All affected providers; and b. Members and potential members, upon request. 42 CFR §438.236 (c) Contract G.4.06	**HSAG Required Evidence:** • Policies and procedures • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) • Plan for dissemination to members (i.e., member newsletter, member handbook, member website) **Evidence as Submitted by the MCO:** • IA_CPG PHG Draft Procedure – Section IIC, pages 4 and 5. • IA Provider Manual 020923, Pg 78-79, Chapter 9, Quality, Sub-sections: Clinical Practice Guidelines & Preventive health Guidelines • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 89 “Guidelines to Keep you Healthy” • IA_QualityMemberWebsite – entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has processes in place to disseminate the guidelines to providers and members.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Application of Guidelines		
6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. 42 CFR §438.236 (d) Contract G.4.05	**HSAG Required Evidence:** • Policies and procedures • Coverage guidelines/criteria • Plan for member educational guidance (i.e., disease management) **Evidence as Submitted by the MCO:** • IA_CPG PHG Draft Procedure – Pg. 1 Section I, Pg. 5 Section E and page 5, Section D. • IA_2023 HCS Program Description; page 36 • Plan for Member Education: Entire Document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa makes decisions for utilization management, member education, coverage of services which are consistent with practice guidelines.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard XII—Practice Guidelines						
Met	=	6	X	1	=	6
Not Met	=	0	X	0	=	0
Total	=	6	**Total Score**		=	6
				Total Score ÷ Total	=	100%

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCO establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program *(called the Quality Management/Quality Improvement [QM/QI] program in Iowa)* for the services it furnishes to its members. 42 CFR §438.330(a)(1) Contract G.5.01 Contract G.5.06	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; all pages • IA _Annual and Five-Year Quality HCS Work Plan Draft, all pages • IA _Quality Program Management Draft Policy, entire document • IA _Quality Program Management Draft Procedure, entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") QAPI Program Description details our ongoing quality assessment and performance improvement program. The QAPI Work Plan lists the objectives with identified partners responsible, the timeline, and action plan to achieve the objectives.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
2. *The QAPI program description, workplan, and program evaluation are exclusive to Iowa and do not contain documentation from other State Medicaid programs or product lines operated by the MCO.* Contract G.5.02	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; all pages and page 1 • IA _Annual and Five-Year Quality HCS Work Plan Draft; page 1, all pages • IA _Quality Program Management Draft Procedure, page 1	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa (MHI) QAPI Program Description Work plan are exclusive to Iowa.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
3. *The QAPI program includes written policies and procedures for quality improvement including methods, timelines, and individuals responsible for completing each task.* Contract G.5.02(i)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 13, 30, 32 • IA _Quality Program Management Draft Policy, entire document • IA _Quality Program Management Draft Procedure, h, iv., page 8	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa QAPI Program Description and policies and procedures detail our ongoing quality assessment and performance improvement program. The QAPI Work Plan lists the objectives with identified partners responsible, the timeline, and action plan to achieve the objectives.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
4. *The MCO makes all information about its QAPI program available to providers and members.* Contract G.5.02	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Planned member and provider communications and/or website link **Evidence as Submitted by the MCO:** • IA _Communication of Quality Measures Draft Policy, entire document	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• IA _Communication of Quality Measures Draft Procedure, C & D, page 3 • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 5, 24, 90 • IA _Annual and Five-Year Quality HCS Work Plan Draft; page 8 • IA _Provider Manual, Chapter 9, Planned Provider Communications pages 67-83 or www.molinahealthcare.com • IA _Quality Member Website, Planned Member Communications, screenshot	
MCO Description of Process: Molina Healthcare of Iowa has processes in place to make our Quality program available to Iowa members and providers.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Basic Elements of QAPI Programs		
5. *The QAPI program includes an annual and prospective five (5) year QAPI workplan that sets measurable goals, establishes specific objectives, identifies the strategies and activities to be undertaken, monitors results, and assesses progress toward the goals.* Contract G.5.02(a)	**HSAG Required Evidence:** • Policies and procedures • QAPI workplan(s) **Evidence as Submitted by the MCO:** • IA _Annual and Five-Year Quality HCS Work Plan Draft, all pages • IA _ Quality Program Management Draft Procedure, pages 1, 10	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa QAPI Work Plan lists the objectives with identified partners responsible, the timeline, and action plan to achieve the objectives.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
6. *The QAPI program includes dedicated resources (staffing, data sources, and analytical resources), including a quality committee that oversees the QAPI functions.* Contract G.5.02(b)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Quality committee charter • Organizational chart **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 6, 11,23, 24, 27, 28, 29, 30, 31, 32, 33, 42, 43, 83, 84, 85, 86, 88, 89. 90, 92 • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary, Organizational Chart, pages 42, 43 • IA _Quality Committee Charter 2023, entire document • IA _Quality Program Management Draft Policy, page 7 • IA _Quality Program Management Draft Procedure, page 1	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has dedicated resources, specifically for Quality, to oversee the QAPI functions.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
7. *The MCO has a quality committee, which includes medical, behavioral health, and long-term services and supports (LTSS) staff and network providers.* a. *This committee analyzes and evaluates the results of QAPI activities, recommends policy decisions, ensures that providers are involved in the QAPI program, institutes needed actions, and ensures that appropriate follow-up occurs.* b. *This committee also reviews and approves the QAPI program description, annual evaluation, and associated workplan prior to submission to HHS.* c. *The committee keeps written minutes of all meetings and a copy of the signed and dated written minutes for each meeting*	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Quality committee charter • List of quality committee members with credentials and position titles • All quality committee meeting minutes that have occurred • Quality committee meeting minutes showing approval of most recent QAPI program and workplan • Notice(s) to HHS of quality committee meetings **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
is available on-file and is made available for review upon request by HHS or its designee. d. *The MCO provides HHS with ten (10) days advance notice of all regularly scheduled meetings of the QM/QI committee.* Contract G.5.05	• 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 6, 27,28, 30, 31, 34, 42 • IA _Quality Committee Charter 2023, entire document • IA _Attestation for Standard XIV, Element 7 • IA _Quality Program Management Draft Policy, entire document • IA _Quality Program Management Draft Procedure, page 14	
MCO Description of Process: Molina Healthcare of Iowa has a robust Quality committee that analyzes and evaluates results of all QAPI activities.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
8. *The QAPI program addresses physical health, behavioral health, and LTSS with appropriate input from providers and members.* Contract G.5.01 Contract G.5.02(c)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Plan for obtaining input from providers • Plan for obtaining input from members **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 5, 8, 9, 14, 17, 20, 21,22, 49-70, 85-87, 89, 91, 99 • IA _Annual and Five-Year Quality HCS Work Plan Draft; pages 11-17, 18-20, 21-23, 30-32, 33-34 • IA _Quality Program Management Draft Procedure	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program has processes in place to ensure input is received from both members and providers.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
9. The QAPI program includes mechanisms to assess both underutilization and overutilization of services. 42 CFR §438.330(b)(3) Contract G.5.09	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Plan to assess underutilization of services • Plan to assess overutilization of services **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 18, 19, 22, 33, 90 • IA _Annual and Five-Year Quality HCS Work Plan Draft; pages 78, 82 • IA HCS-362.01 Monitoring to Ensure Appropriate Utilization Procedure _IA RR • IA _Over and Under Utilization Assessment Plan	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program has processes in place to assess both underutilization and overutilization of services through ongoing monitoring.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
10. *The QAPI program includes a process to monitor variation in practice patterns and identify outliers.* Contract G.5.02(e)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Plan to monitor variation in practice partners and identify outliers **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 9-10, 27, 99 • IA _Annual and Five-Year Quality HCS Work Plan Draft; pages 78, 83	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• IA_ CPG_PHG Draft procedure • IA _Annual and Five-Year Quality HCS Work Plan Draft; page 83	
MCO Description of Process: Molina Healthcare of Iowa's QAPI program has processes to monitor variation in practice patterns and identify outliers.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
11. *The QAPI program includes strategies designed to promote practice patterns that are consistent with evidence-based clinical practice guidelines through the use of education, technical support, and provider incentives.* Contract G.5.02(f)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Plan to promote practice patterns (e.g., provider educational materials, technical supports, provider incentive program) **Evidence as Submitted by the MCO:** • IA_CPG_PHG Draft procedure, entire document • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 9-10, 18,19, 23,38-39, 49-70, 74-76, 82, 88-93, 99-103 • IA_CPG Provider Promotion Plan, entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program has processes to promote clinical practice guidelines through the use of education, technical support, and provider incentives		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
12. *The QAPI program includes monitoring of prescribing patterns of network prescribers to improve the quality of care and coordination of services provided to members through strategies such as:* a. *Identifying medication utilization that deviates from current clinical practice guidelines.*	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Plan to monitor the prescribing patterns of network prescribers **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
b. *Identifying members whose utilization of controlled substances warrants intervention.* c. *Providing education, support, and technical assistance to providers.* d. *Monitoring the prescribing patterns of psychotropic medication to children, including children in foster care.* Contract G.5.02(h)	• 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 18, 19, 27, 88, 94-98 • IA _Pharm Patient Safety _Procedure V.E. • IA _Pharm Patient Safety _Addendum-entire document • IA _Annual and Five-Year Quality HCS Work Plan Draft, page 84	
MCO Description of Process: Molina Healthcare of Iowa's QAPI program has processes to monitor prescribing patterns of network providers to improve the quality of care and coordination of services provided to members.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
13. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by HHS in the quality strategy. 42 CFR §438.330(b)(4) Contract G.5.10	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Definition of members with special health care needs • Plan to assess members with special health care needs, including metrics/performance measures **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 9, 20 (includes definition), 38 • IA _Annual and Five-Year Quality HCS Work Plan Draft, page 85 • IA _Quality Program Management Draft Policy • IA _Quality Program Management Draft Procedure	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program has processes to assess the quality and appropriateness of care provided to members with special health care needs.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
14. *The QAPI program includes a system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment of special needs populations, and other quality improvement activities found valuable by the MCO or required by HHS.* Contract G.5.02(j)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Plan for monitoring services **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 7, 15, 21, 27, 83, 84, 85, 91, 99-103 • IA _Annual and Five-Year Quality HCS Work Plan Draft, page 86, • IA _Quality Program Management Draft Procedure, page 10	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program has processes to monitor services with data collection, assessment of special needs population, and quality improvement activities.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
15. *The QAPI program incorporates clinical studies and use of HEDIS rate data, health care quality measures for Medicaid-eligible adults described in Section 1139B of the Social Security Act, using the survey tool identified by HHS (i.e., Iowa Participant Experience Survey [IPES]), and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members.* Contract G.5.02(k)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Plan to assess the quality and appropriateness of care provided to members **Evidence as Submitted by the MCO:3** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 9-10, 21, 24-25, 27, 36, 49-70, 75, 83,85, 86, 91 • IA _Monitoring and Reporting Quality Measures Draft Procedure, entire document	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• IA _Survey Tool Policy, entire document • IA _Survey Tool Procedure, entire document • IA _Member Satisfaction Overall Analysis Draft Policy, page 3 • IA _Annual and Five-Year Quality HCS Work Plan Draft, page. 87, • IA _Quality Program management Draft Procedure, page 10	
MCO Description of Process: Molina Healthcare of Iowa's QAPI program utilizes clinical studies, HEDIS rate data, and survey tools to assess quality and appropriateness of care provided to members.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
16. *The QAPI program includes procedures for a provider pay-for-performance program.* Contract G.5.02(p)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Plan for provider pay-for-performance program documentation **Evidence as Submitted by the MCO:** • IA _Pay-for-Performance Draft Procedure, entire document • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; page 82 • IA _Final VBP Roadmap, entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program includes a provider pay-for-performance program.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
17. *The QAPI program includes procedures for a member incentive program aligned with the Healthiest State Initiative and other quality outcomes to increase quality outcomes and encourage appropriate utilization of health services and healthy behaviors.*	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Plan for member incentive program documentation	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract G.5.02(q) Contract G.5.03	**Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 44 - 47 • IA _Annual and Five-Year Quality HCS Work Plan Draft, page 88, • IA _Quality Program Management Draft Procedure, pages 1&9	
MCO Description of Process: Molina Healthcare of Iowa's QAPI program has processes in place for a member incentive program aligned with the Healthiest State Initiative and other quality outcomes to improve outcomes and encourage utilization of services.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
18. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including: a. Assessment of care between care settings; and b. Comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable. 42 CFR §438.330(b)(5)(i) Contract G.5.11	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Plan to assess members receiving LTSS, including metrics/performance measures **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 8,9, 27. 88 • IA _Annual and Five-Year Quality HCS Work Plan Draft, page 89, • IA _Quality Program Management Draft Procedure, page 1	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program has processes in place to assess the quality and appropriateness of care furnished to members using LTSS.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Performance Measurement		
19. The QAPI program must include the collection and submission of performance measurement data. The MCO annually: a. Measures and reports to HHS on its performance, using the standard measures required by HHS; b. Submits to HHS data, specified by HHS, which enables HHS to calculate the MCO's performance using the standard measures identified by HHS; or c. Performs a combination of the activities described in sub elements (a) and (b). 42 CFR §438.330(b)(2) 42 CFR §438.330(c) Contract G.5.02(m-n) Contract G.5.08 Contract G.5.18	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 6, 9, 11, 12, 24. 25, 83, 85 • IA _Monitoring and Reporting Quality Measures Draft Procedure, page 5 • IA _Annual and Five-Year Quality HCS Work Plan Draft, page 90	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program includes collection and submission of performance measurement data as required by HHS.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
20. *The QAPI program includes procedures for collecting and assuring accuracy, validity, and reliability of performance outcome rates that are consistent with best practice protocols developed in the public or private sector.* Contract G.5.02(o)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 24-25, 83 • IA _ Monitoring and Reporting Quality Measures Draft Procedure, pages 1&2	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa's QAPI program uses best practice protocols to collect and assure accuracy, validity, and reliability of performance outcome rates.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Performance Improvement Projects		
21. The QAPI program must include performance improvement projects (PIPs). a. The MCO must conduct PIPs that focus on both clinical and nonclinical areas. 42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) Contract G.5.07	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 10, 14. 21 • IA _ Annual and Five-Year Quality HCS Work Plan Draft, page 91, includes Plan to submit Performance Improvement Projects, 105 • IA _ Quality Program Management Draft Procedure, page 17	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program includes clinical and nonclinical performance improvement projects.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
22. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements: a. Measurement of performance using objective quality indicators; b. Implementation of interventions to achieve improvement in the access to and quality of care;	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 13, 15, 83	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
c. Evaluation of the effectiveness of the interventions based on the performance measures required by HHS; and d. Planning and initiation of activities for increasing or sustaining improvement. 42 CFR §438.330(d)(2) Contract G.5.19–G.5.23	• IA _ Annual and Five-Year Quality HCS Work Plan Draft, page 91, includes Plan to submit Performance Improvement Projects, page 105 • IA _ Quality Program Management Draft Procedure, page 17	
MCO Description of Process: Molina Healthcare of Iowa's performance improvement projects include objective quality indicators, interventions, evaluation with plans for further increasing or sustaining improvement.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
23. The MCO reports the status and results of each PIP to HHS as requested, but not less than once per year. 42 CFR §438.330(d)(3) Contract G.5.24	**HSAG Required Evidence:** • Policies and procedures • Deliverable grid/calendar **Evidence as Submitted by the MCO:** • IA _ Annual and Five-Year Quality HCS Work Plan Draft, page 91, includes Plan to submit Performance Improvement Projects, 105 • IA _ Quality Program Management Draft Procedure, page 17	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program reports the status and results of each performance improvement project to HHS as requested, but not less than once per year.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Critical Incidents		
24. The QAPI program includes participation in efforts by HHS to prevent, detect, and remediate critical incidents (consistent with assuring member health and welfare per 42 CFR §441.302 and §441.730[a]) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h). a. *The MCO develops, implements, and adheres to policies and procedures to:* i. *Address and respond to incidents;* ii. *Report incidents to the appropriate entities per required time frames; and* iii. *Track and analyze incidents.* iv. *The MCO uses this information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement, and develop, implement, and adhere to appropriate strategies to reduce the occurrence of incidents and improve the quality of care.* 42 CFR §438.330(b)(5)(ii) Contract G.5.12 Contract G.5.17	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Critical incident tracking and reporting templates **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 18, 22, 33 • IA _ Annual and Five-Year Quality HCS Work Plan Draft, pages 6, 92 • IA_HCS-197 Critical Incidents Policy _ IA RR • IA_HCS-197.01 Critical Incidents Procedure _ IA RR, page 2 • IA_CI Reporting, entire document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program includes processes to prevent, detect, and remediate critical incidents.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element. **Recommendations:** HSAG recommends that the MCO enhance its policies and procedures to further expand on how case-specific and systemic trends and patterns will be used to identify opportunities for improvement to reduce occurrences of incidents and improve quality of care provided to members. Additionally, the MCO should continue to work with HHS on reporting critical incidents through the State's critical incident reporting system, and update its tracking system, as appropriate, to include all required data fields.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
25. *The MCO requires internal staff and network providers to:* a. *Report critical incidents;* b. *Respond to critical incidents;* c. *Document critical incidents; and* d. *Cooperate with any investigation conducted by the MCO or outside agency.* Contract G.5.14	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Provider materials, such as the provider manual • Staff training materials **Evidence as Submitted by the MCO:** • IA _ Annual and Five-Year Quality HCS Work Plan Draft, page 92 • 2023 QM_QI program Description Molina Healthcare of Iowa Preliminary; page 18 • IA_HCS-197.01 Critical Incidents Procedure IA RR., page 1 • IA Provider Manual 020923, pages 69, 151-155 • IA_CI Database CHAMP Training	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa requires both internal staff and network providers to report, respond, document to critical incidents and cooperate with any investigation.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
26. *The MCO provides staff and provider training on critical incident policies and procedures at least annually.* Contract G.5.15	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Provider training materials • Staff training materials • Critical incident training tracking mechanism **Evidence as Submitted by the MCO:** • IA _ Annual and Five-Year Quality HCS Work Plan Draft, page. 92 – Tracking Mechanism • IA_HCS-197.01 Critical Incidents Procedure _ IA RR, page 3	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• IA_CI Database CHAMP Training • IA Provider Manual 020923, pages 151-155 • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 18, 22, 33.	
MCO Description of Process: Molina Healthcare of Iowa trains staff and providers on critical incident policies and procedures at least annually.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element. **Recommendations:** In addition to the MCO's utilization management and care management teams being trained on the MCO's critical incident policies and procedures at least annually, HSAG recommends that the MCO also train member services staff members on what constitutes a critical incident versus a grievance, so member services staff members can route the reported incident to the appropriate team for further action if member services should call regarding a critical incident.		
Required Actions: None.		
27. *The MCO takes corrective action as needed to ensure provider compliance with critical incident requirements.* Contract G.5.16	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Corrective action plan template(s)	☒ Met ☐ Not Met
	Evidence as Submitted by the MCO: • IA _ Annual and Five-Year Quality HCS Work Plan Draft, page 92 • IA_QAPI Program Description; pages 4,18 • IA_HCS-197.01 Critical Incidents Procedure _IA RR, page 2 • IA _Corrective Action Plan letter _template	
MCO Description of Process: Molina Healthcare of Iowa takes corrective action to ensure provider compliance with critical incident requirements.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Provider Preventable Conditions		
28. The MCO does not make payment to a provider for provider-preventable conditions that meet the following criteria: a. Is identified in the State Plan; b. Has been found by the HHS, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; c. Has a negative consequence for the member; d. Is auditable; e. Includes, at a minimum: i. Wrong surgical or other invasive procedure performed on a patient; ii. Surgical or other invasive procedure performed on the wrong body part; and iii. Surgical or other invasive procedure performed on the wrong patient. Pursuant to 42 CFR §447.26(c)(1-3), no reduction in payment for a provider preventable condition is imposed when the condition defined as a provider preventable condition for a particular member existed prior to the initiation of treatment for that member by that provider. Reductions in provider payment may be limited to the extent that the identified provider-preventable conditions would otherwise result in an increase in payment; and the MCO can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions. 42 CFR §438.3(g) 42 CFR § 447.26(b) Contract F.7.01	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Provider materials, such as provider contract and/or provider manual • Claims processing guidelines **Evidence as Submitted by the MCO:** • IA _Prov Prev. Cond. Policy, entire policy • IA_MHI.CLMS.03.02.02, Entire Policy • IA _Annual and Five-Year Quality HCS Work Plan Draft, page. 93 • IA_ Provider Manual 020923; Quality of Care Chapter & Claims Chapter 12- Claims and Compensation, Hospital Acquired conditions and Present on Admission Program Sub-section, pg. 112-113 • IA _Attestation for Standard XIV, Elements 28-30 • IA _Molina Iowa PSA (FFS), page 6 Section 2.6b Participation in QI Program • IA_MHI.CLMS.03.02 Claims Adjudication Procedure, entire document • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary – see MCO description to reference Work Plan	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa does not make payment to a provider for defined and identified provider-preventable conditions. Please review the companion document to the Program Description – page 93 of the Work Pl–n - for specifics about the Provider Preventable Condition process. In addition, review the policies and provider manual for detailed procedures.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
29. The MCO requires all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. 42 CFR 438.3(g) 42 CFR 434.6(a)(12) Contract F.7.02	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Provider materials, such as provider contract and/or provider manual **Evidence as Submitted by the MCO:** • IA _Prov Prev. Cond. Policy, entire policy • IA_MHI.CLMS.03.02.02– Entire Policy • IA _Annual and Five-Year Quality HCS Work Plan Draft, page 93 • IA Provider Manual 020923; Quality of Care Chapter & Claims Chapter • IA _Attestation for Standard XIV, Elements 28-30 • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary – see MCO description to reference Work Plan	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa requires all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. Please review the companion document to the Program Description – page 93 of the Work Pl–n - for specifics about the Provider Preventable Condition process. In addition, review the policies and provider manual for detailed procedures.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
30. The MCO reports all identified provider-preventable conditions in a form or frequency as specified by HHS. 42 CFR 438.3(g) Contract F.7.03	**HSAG Required Evidence:** • Policies and procedures • Deliverable grid/calendar **Evidence as Submitted by the MCO:** • IA _Annual and Five-Year Quality HCS Work Plan Draft, page 93 • IA_GC-03 Iowa Reporting Policy, page 1 • IA _Deliverable Grid _Calendar	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa reports all identified provider-preventable conditions annually as prescribed in the Iowa Health Link Reporting Manual utilizing the D-11 Annual HEDIS Report and as frequently as requested by HHS.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Member Experience		
31. *The QAPI program includes procedures to assess member satisfaction.* Contract G.5.02(r)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Plan to assess member satisfaction **Evidence as Submitted by the MCO:** • IA _Member Satisfaction Overall Analysis Draft Procedure, page 1 • IA _Member Satisfaction Overall Analysis Draft Policy, entire document • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 6, 9, 23, 33, 85-86, 91 • IA _Annual and Five-Year Quality HCS Work Plan Draft; pages 20, 23, 26, 27, 29	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary, Appendix I, page 85-86	
MCO Description of Process: Molina Healthcare of Iowa's QAPI program includes processes to assess member satisfaction.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
32. *The MCO implements utilization of the survey tool (i.e., IPES) identified by HHS for members receiving home- and community-based (HCBS) services.* Contract G.5.02(l)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 27, 86, 89 • IA _Survey Tool Policy, entire document • IA _Survey Tool Procedure, entire document • IA _Annual and Five-Year Quality HCS Work Plan Draft; page 94	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program utilizes a survey tool identified by HHS for members receiving home and community-based services.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Value-Based Purchasing Programs		
33. *The MCO identifies the goals it has set to address its strategy for improving the delivery of health care benefits and services to its members via value-based purchasing (VBP) programs.* a. *The MCO identifies the steps to be taken including a timeline with target dates and providing reporting on such timelines*	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Plan for VBP program(s)	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
and targets consistent with the obligations in the Reporting Manual. b. *The MCO's VBP programs align with the Quadruple Aim, including specific detail for the value-based purchasing requirements described in Section E of the Contract.* Contract G.5.27 Contract G.5.29	**Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 3, 48, 50, 82 • IA _Pay-for-Performance Draft Procedure, entire document • IA _Final VBP Roadmap • IA _Annual and Five-Year Quality HCS Work Plan Draft; page 95 • IA_GC-03 Iowa Reporting Policy, page 1	
MCO Description of Process: Molina Healthcare of Iowa has strategies and timelines in place to improve delivery of health care benefits and services to members via value-based purchasing programs which are aligned with the Quadruple Aim.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
QAPI Program Reviews, Analysis, and Evaluation		
34. The MCO must develop a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation must include: a. The performance on the measures on which it is required to report; b. The outcomes and trended results of each PIP; and c. The results of any efforts to support community integration for members using LTSS. 42 CFR §438.330(e) Contract G.5.26	**HSAG Required Evidence:** • Policies and procedures • Plan to evaluate the results of any efforts to support community integration for members using LTSS **Evidence as Submitted by the MCO:** • IA _Annual and Five-Year Quality HCS Work Plan Draft; page 96 • IA _Quality Program Management Draft Procedure • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 40, 88, 92	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa has robust processes in place to evaluate the impact and effectiveness of the QAPI Program.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
35. *The QAPI program includes analysis of the effectiveness of treatment services, employing both standard measures of symptom reduction/management, and measures of functional status.* Contract G.5.02(g)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI workplan • Plan to analyze treatment services effectiveness **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary; pages 27, 83, 88-89 • IA _Annual and Five-Year Quality HCS Work Plan Draft; page 96 • IA _Quality Program Management Draft Procedure, page 17	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's QAPI program utilizes standard measures of symptom reduction/management, and measures of functional status to analyze effectiveness of treatment services.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Organizational Structure and Staffing		
36. *The MCO has in place an organizational and operational structure capable of fulfilling all Contract requirements. This structure supports collection and integration of data across the MCO's delivery system and internal functional units to accurately report the MCO's performance. The MCO has in place sufficient administrative and clinical staff and organizational components to achieve compliance with all Contract requirements and performance standards. The MCO manages the functional linkage of the following major operational areas:* a. *Administrative and fiscal management;* b. *Member services;* c. *Provider services;* d. *Care Coordination;*	**HSAG Required Evidence:** • Policies and procedures • Organizational chart(s) • Committee structure and charters • Implementation Plan (as requested via the Questionnaire) **Evidence as Submitted by the MCO:** • 2023 QM_QI Program Description Molina Healthcare of Iowa Preliminary, entire document • IA _RRQ _Attachment 7_Org Chart _Operational Areas • IA_RRQ Attachment 20_QAPI Committee Structure • IA_RRQ Attachment 6_Implementation Plan	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
e. *Marketing;* f. *Provider enrollment;* g. *Network development and management;* h. *Quality management and improvement;* i. *Utilization and care management;* j. *Behavioral and physical health;* k. *Information systems;* l. *Performance data reporting and encounter claims submission;* m. *Claims payments; and* n. *Grievances and appeals.* Contract A.03		
MCO Description of Process: Molina Healthcare of Iowa meets the requirements of Iowa Health Link Contract A.03 as evidenced in the documents submitted for this element. Although committee structures are in place, charters for each committee are under development.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
37. *The MCO provides an initial operational staffing plan to HHS following the requirements in Section A of the Contract. In its staffing plan, the MCO:* a. *Ensures that staff delivering care coordination and community-based case management services are based in Iowa at locations that will facilitate the delivery of in-person services as appropriate;* b. *Includes no less than the staffing areas listed in the Staffing Checklist;* c. *Encourages a local presence in Iowa, particularly in relation to the delivery of member and provider services;* d. *Includes a backup personnel plan, including a discussion of the staffing contingency plan for:*	**HSAG Required Evidence:** • Policies and procedures • Job descriptions for all personnel defined in the Staffing Checklist • Operational Staffing Plan (as requested via the Questionnaire) • HSAG will also use the results of the Staffing Checklist **Evidence as Submitted by the MCO:** • Iowa HSAG- Staffing Checklist-JD's • IA_GC-04 Molina Iowa Staffing Policy, pages 1-2 • IA _RRQ _ Attachment 7_Org Chart _Operational Areas • IA _ Key Personnel Table	☐ Met ☒ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
i. *The process for replacement of personnel in the event of a loss of key personnel or others before or after signing the Contract;* ii. *Allocation of additional resources to the Contract in the event of an inability to meet a performance standard;* iii. *Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience;* iv. *The time frame necessary for obtaining replacements;* v. *The method of bringing replacements or additions up to date regarding the Contract;* e. *Includes a resume for each key personnel member; and* f. *Describes what functions are proposed to be conducted outside of Iowa and how out-of-State staff will be supervised to ensure compliance with Contract requirements.* Contract A.04-A.07	• MOL_IA2023_RR_Std XIV _ Staffing Checklist	
MCO Description of Process: Molina Healthcare of Iowa's initial operating staffing plan meets the requirements as set forth in the contract.		
HSAG Findings: While the MCO maintained a staffing plan, there remains a significant number of staff vacancies (e.g., grievance and appeal staff, member and provider services, credentialing, utilization management). HSAG recognizes that the hiring of staff is an ongoing process; therefore, HSAG expects that the MCO will be able to demonstrate progression in the hiring of staff through the submission of ongoing reports.		
Required Actions: In order to receive a *Met* score for this element, the MCO must demonstrate that it has made significant progress in filling the open staff positions.		
38. *The MCO provides initial and ongoing training and ensures all staff are trained in the areas listed in the Staff Training Checklist.* a. *The MCO maintains documentation to confirm staff training, curriculum, schedules, and attendance.* Contract A.13	**HSAG Required Evidence:** • Policies and procedures • Staff training tracking mechanisms • Staff Training Plan (as requested via the Questionnaire) • HSAG will also use the results of the Staff Training Checklist	☐ Met ☒ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCO: • IA_GC-04 Molina Iowa Staffing Policy, page 2 Molina Staff Training Responsibilities • IA_C-01.3 Effective Training and Education. Entire Document • IA _RRQ _Attachment 9_Training Plan • MOL_IA2023_RR_StdXIV_Staffing Training Checklist_T1 • IA _iLearn- screenshot	
MCO Description of Process: Molina Healthcare of Iowa provides initial and ongoing training and ensures all staff are trained in the areas listed in the Staff Training Checklist.		
HSAG Findings: While the MCO demonstrated that it has the processes in place to train staff initially and annually, the Molina Staff Resources Monitoring documents submitted after the site review did not support that the MCO has fully trained staff members in most program areas. HSAG recognizes that the hiring of staff and subsequent training of staff is an ongoing process; therefore, HSAG expects that the MCO will be able to demonstrate progression in the training of staff through the submission of ongoing reports.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Demonstrate that it has made significant progress in fully training staff members.		
Accreditation		
39. *The MCO attains and maintains accreditation from the National Committee for Quality Assurance (NCQA).* a. *If not already accredited, the MCO demonstrates it has initiated the accreditation process as of the Contract effective date.* b. *The MCO achieves accreditation at the earliest date allowed by NCQA.* c. *Accreditation is maintained throughout the life of the Contract at no additional cost to HHS.* d. *When accreditation standards conflict with the standards set forth in the Contract, the Contract prevails unless the accreditation standard is more stringent.* e. *MCOs providing services to LTSS services to members shall pursue NCQA LTSS Distinction for Health Plans.*	**HSAG Required Evidence:** • Proof of accreditation or plan/timeline for obtaining accreditation **Evidence as Submitted by the MCO:** • IA _Plan for NCQA Accreditation, entire document • IA _Annual and Five-Year Quality HCS Work Plan Draft; page 97, (including Plan for accreditation)	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract G.7.03		
MCO Description of Process: Molina Healthcare of Iowa has a plan to achieve accreditation from the National Committee for Quality Assurance.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		
Maintenance and Retention of Records		
40. *The MCO maintains a medical records system that:* a. *Identifies each medical record by State identification number;* b. *Identifies the location of every medical record;* c. *Places medical records in a given order and location;* d. *Maintains the confidentiality of medical records information and releases the information only in accordance with applicable law;* e. *Maintains inactive medical records in a specific place;* f. *Permits effective professional review in medical audit processes;* g. *Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.* Contract G.2.32	**HSAG Required Evidence:** • Policies and procedures • HSAG will use the results of the systems demonstration **Evidence as Submitted by the MCO:** • IA _Standards of Medical Record Documentation Draft Policy, entire document • IA _Standards of Medical Record Documentation Draft Procedure, pages 1,2, 4 & 5	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa maintains a robust, compliant, and confidential medical records system that permits auditing and follow-up treatment.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirement of this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program						
Met	=	38	X	1	=	38
Not Met	=	2	X	0	=	0
Total Applicable	=	40	Total Score		=	38
				Total Score ÷ Total	=	95%

Standard XIV—Staff Training Checklist		
Reference	**Required Components**	
The MCO provides initial and ongoing training and ensures all staff are trained in the major components of the Contract, including:		
Contract A.13(i)	1. *Contract requirements and State and Federal requirements specific to job functions.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • IA RRQ_ Attachment 9_Training Plan	
Contract A.13(ii)	2. *In accordance with 42 CFR §422.128, training on the MCO's policies and procedures on advance directives.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • CM- Advance Care Planning and the Five Wishes	
Contract A.13(iii)	3. *Initial and ongoing training on identifying and handling quality of care concerns.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • Critical Incidents and Reporting 2021.pdf • IA_CI Database CHAMP Training	
Contract A.13(iv)	4. *Cultural sensitivity training.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • Person Centered Care: Care Planning and Cultural Competency • Introduction to Cultural Competency Module 1- 2022 • Cultural Competencyand... Module 2_2022	
Contract A.13(v)	5. *Training on fraud and abuse and the False Claims Act as further described in Section I of the Contract.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • Fraud, Waste, and Abuse – General Training 2022	
Contract A.13(vi)	6. *Health Information Portability and Accountability Act (HIPAA) training.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • HIPAA 101 HIPAA Privacy Training – New Hire • HIPAA Privacy & Security – Annual Refresher Training_2022 • HIPAA Privacy & Security Training 2022 – New Hire	

Standard XIV—Staff Training Checklist		
Reference	**Required Components**	
Contract A.13(vii)	7. *Clinical protocol training for all clinical staff.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • Reference Training Agendas: - HCS UM NEO PEGA Master Deck - UM Training Agenda- Combined Roles and CRP Role Specific - UM Training Agenda – CRC IP Role Specific - UM Training Agenda – CRC PA Role Specific NEO • Molina Clinical Documentation_ Assessment Summary, PPT • Molina Clinical Documentation_ Introduction PPT	
Contract A.13(viii)	8. *Training regarding interpretation and application of utilization management (UM) guidelines for all UM staff.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • UM Training Agenda-Combined Roles and CRP Role Specific • UM Overview – NEO	
Contract A.13(ix)	9. *Assessment processes, person-centered planning, and population specific training relevant to the enrolled populations for all care managers.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • Care Management Overview PPT • CCA Assessments- HRA, Condition Specific and Direct Referral, PPT • Individualized Care Plan, PPT • Interdisciplinary Care Team (ICT), PPT • CM-Risk Strat- Programmatic Levels, PPT • Person Centered Health Care – Care Plan and Cultural Competency, PPT • Discharge Planning and ToC Program, PPT • Reference Training Agendas: - CM Training Agenda_Clinical Staff_NEO 01.31.23 - CM Training Agenda_Non-Clinical NEO_01.31.2023 - BH Training Agenda	

Standard XIV—Staff Training Checklist		
Reference	**Required Components**	
Contract A.13(x)	10. *Training and education to understand abuse, neglect, exploitation, and prevention including the detection, mandatory reporting, investigation, and remediation procedures and requirements.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • Critical Incidents and Reporting 2021.pdf	
Contract A.13(xi)	11. *Training specific to Iowa long-term services and supports (LTSS) providers and non-Medicaid resources.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • LTSS- Case Management Responsibilities, PPT • LTSS-FLSR Training, PPT • LTSS-NF Community Reintegration Process, PPT • LTSS-Second level Review Training, PPT • LTSS Service Plan Table (SPT) Training, PPT • LTSS and mCare Training Agenda • Unable to Contact PPT_07.01.22 • Molina Help Finder	

Standard XIV—Staffing Checklist		
Reference	**Required Components**	
The MCO's staffing includes the following key personnel positions:		
Contract A.07(e)(1)	1. *Chief Executive Officer (CEO): Responsible for overseeing the entire healthcare plan of the MCO. Has full and final responsibility for Contract compliance.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Jennifer Vermeer	
Contract A.07(e)(2)	2. *Chief Operating Officer (COO): Responsible for oversight of all day-to-day operations of the healthcare plan operations. Has oversight of all functional operational areas within the healthcare plan. Reports directly to the CEO.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Richard Russell	
Contract A.07(e)(3)	3. *Medical Director: Is an Iowa-licensed physician in good standing. Ensures oversight of all clinical functions including, but not limited to, disease management and care coordination programs, the development of clinical care guidelines and utilization management (UM). Ensures for the coordination and implementation of the QAPI Program. Attends and actively participates in any scheduled quality committee meetings as directed by HHS. Directs the MCO's internal UM committee.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Timothy Gutshall	

Standard XIV—Staffing Checklist		
Reference	**Required Components**	
Contract A.07(e)(4)	4. *Chief Financial Officer: Oversees the MCO's budget, accounting systems, and financial reporting for the program.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Dave Reese	
Contract A.07(e)(5)	5. *Compliance Officer: Accountable to the MCO's executive leadership and dedicated full-time to the Contract with the requirements of Section I.5 of the Contract. This individual will be the primary liaison with HHS (or its Designees) to facilitate communications between HHS, HHS' contractors, and the MCO's executive leadership and staff. This individual maintains a current knowledge of federal and State legislation, legislative initiatives, and regulations that may impact the program. It is the responsibility of the Compliance Officer to comply with all HIPAA and privacy regulations as well as coordinate reporting to HHS and to review the timeliness, accuracy, and completeness of reports and data submissions to HHS. The Compliance Officer, in close coordination with other key personnel, has primary responsibility for ensuring all MCO functions are in compliance with the terms of the Contract.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Anthony Carroll	
Contract A.07(e)(6)	6. *Pharmacy Director/Coordinator: Is an Iowa licensed pharmacist who oversees the pharmacy benefits under the Contract. Has experience as a Medicaid Pharmacy Director or equivalent Medicaid pharmacy experience, inclusive of drug rebate. Ensures oversight and coordination of all MCO and PBM pharmacy requirements including drug rebate. Attends the HHS Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings.*	Y ☒ N ☐

Standard XIV—Staffing Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Candace Jordan	
Contract A.07(e)(7)	7. *Grievance and Appeals Manager: Manages the MCO's grievance and appeals process, ensuring compliance with processing timelines and policy and procedure adherence.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Jeff Larsen	
Contract A.07(e)(8)	8. *Quality Management Manager: Is an Iowa licensed registered nurse, physician or physician's assistant, or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (HCQM) by the American Board of Quality Assurance and Utilization Review Physicians. The QM Manager oversees the MCO's QAPI program and ensures compliance with quality management requirements and quality improvement initiatives.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Theresa Jennings	
Contract A.07(e)(9)	9. *Utilization Management Manager: Is an Iowa licensed registered nurse, physician, or physician's assistant if required to make medical necessity determinations. This position manages all elements of the MCO's UM program and staff under the supervision of the Medical Director. This includes but is not limited to functions related to prior authorization, medical necessity determinations, concurrent and retrospective reviews, and other clinical and medical management programs as described in the Contract.*	Y ☒ N ☐

Standard XIV—Staffing Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Tami Lewis	
Contract A.07(e)(10)	10. *Behavioral Health Manager: Is an Iowa licensed behavioral health professional such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist or mental health counselor, with experience in both mental health and substance use disorder services. The Behavioral Health Manager ensures that the MCO's behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract. The Behavioral Health Manager coordinates with all functional areas, including quality management, UM, network development and management, provider relations, member outreach and education, member services, Contract compliance and reporting. If the MCO subcontracts with a behavioral health organization (BHO) to provide behavioral health services, the Behavioral Health Manager will continue to work closely with the MCO's other managers to provide monitoring and oversight of the BHO and to ensure the BHO's compliance with the Contract.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Jean McClurken	
Contract A.07(e)(11)	11. *Member Services Manager: Provides oversight of the member services functions of the Contract, including, but not limited to, member helpline telephone performance, member email communications, member education, the member website, member outreach programs, development, and approval and distribution of member materials. The Member Services Manager oversees the interface with HHS or its subcontractors regarding such issues as member enrollment and disenrollment.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's	

Standard XIV—Staffing Checklist		
Reference	**Required Components**	
	• Key Personnel Table • Key Personnel Resumes Complied, Blanca Trevizo	
Contract A.07(e)(12)	12. *Provider Services Manager: Provides oversight of the provider services function of the Contract. This includes, but is not limited to, the provider services helpline, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials, and developing provider outreach programs. The Provider Services Manager, in close coordination with other key personnel, ensures that all of the MCO's provider services operations are in compliance with the terms of the Contract.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Tom Newton	
Contract A.07(e)(13)	13. *Information Systems Manager: Serves as a liaison between the MCO and HHS, or its designee, regarding member encounter data submissions, capitation payment, member eligibility, enrollment, and other data transmission interface and management issues. The IS Manager, in close coordination with other key personnel, ensures all information system security and controls, program data transactions, data exchanges, and other information system requirements are in compliance with the terms of the Contract and all data submissions required for federal reporting. The IS Manager oversees all systems testing, including during the readiness review.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Michael Wharton	

Standard XIV—Staffing Checklist		
Reference	**Required Components**	
Contract A.07(e)(14)	14. *Claims Administrator: Ensures prompt and accurate provider claims processing in accordance with the terms of the Contract.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Irene Armendariz	
Contract A.07(e)(15)	15. *Care Coordination Manager: Ensures oversight of the MCO's care coordination and community-based case management programs. The Care Coordination Manager, at a minimum, is a registered nurse or other medical professional with extensive experience in providing care coordination to a variety of populations. The individual oversees care coordination and community-based case management teams, care plan development, and care plan implementation.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, , Jill Villalobos	
Contract A.07(e)(16)	16. *Program Integrity Manager and Special Investigations Unit Staffing: Ensures oversight of the MCO's Special Investigations Unit (SIU) activity. The MCO ensures that the qualifications of the Program Integrity Manager are equal to those of the HHS Program Integrity Director. The Program Integrity Manager serves as the liaison between the MCO and State agencies, law enforcement, and federal agencies. The Program Integrity Manager is informed of current trends in fraud, waste, and abuse as well as mechanisms to detect such activity. The Program Integrity Manager is located in the Iowa offices. The position is dedicated at least 100% of the time to the oversight and management of the program integrity efforts required under the Contract. The Program Integrity Manager has open and immediate access to all claims, claims processing data, and any other electronic or paper information sufficient to meet the requirements of HHS. The duties include, but are not limited to:* a. *Oversight of the program integrity function under the Contract;* b. *Liaison with Iowa Medicaid in all matters regarding program integrity;*	Y ☒ N ☐

Standard XIV—Staffing Checklist		
Reference	**Required Components**	
	c. *Development and operations of a fraud control program within the MCO claims payment system;* d. *Liaison with Iowa's Medicaid Fraud Control Unit (MFCU) and/or the Office of the Attorney General;* e. *Assure coordination of efforts with HHS and other agencies with regards to program integrity issues.*	
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Scott Campbell	
Contract A.07(e)(17)	17. *Long-Term Services and Supports (LTSS) Manager: Ensures oversight of the MCO's implementation of the State's community based and facility programs. The LTSS Manager, at minimum, has at least five (5) years of experience in LTSS policy and has a comprehensive understanding of CMS rules and regulations. The LTSS Manager oversees long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Key Personnel Resumes Complied, Brian Marston	
Contract A.07(e)(18)	18. *Primary Point of Contact: In addition to all other key personnel and management positions, the MCO designates a primary point of contact with HHS for delivery system reform activities, including managing a specific project plan and reporting on activity and progress towards identified goals, including but not limited to those described in State Innovation Model (SIM). The point person will also serve as the liaison between the MCO and various state agencies, leaders from the healthcare delivery system, other payers, stakeholders, and federal agencies. The point person also is informed of current trends in delivery system reports and have the specific experience within the healthcare delivery system in Iowa.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's	

Standard XIV—Staffing Checklist		
Reference	**Required Components**	
	• Key Personnel Table • Key Personnel Resumes Complied, Tom Newton	
The MCO also includes the following staffing:		
Contract A.07(b)	19. *Prior Authorization and Concurrent Review Staff: Authorizes requests for services and conducts inpatient concurrent review.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Care Review Clinician, Inpatient Review (RN) and Care Review Processor	
Contract A.07(b)	20. *Member Services Staff: Responds to member inquiries via a member services helpline, as well as written and electronic correspondence.*	Y ☐ N ☒
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Supervisor, Member Services, Dir, Member Services, Re, Customer Experience II, and Rep, Customer Experience- Remote	
Contract A.07(b)	21. *Provider Services Staff: Responds to provider inquiries and disputes and provides outreach on provider policies and procedures.*	Y ☐ N ☒
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Specialist, Provider Contracts; Sr Specialist, Provider Contracts; Dir, Provider Contracts; Rep, Provider Services; Sr Rep, Provider Services; Program Director; Dir, Provider Services	

Standard XIV—Staffing Checklist		
Reference	**Required Components**	
Contract A.07(b)	22. *Claims Processing Staff: Ensures timely and accurate processing of claims.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Examiner, Claims; Sr Adjuster; Claims; Manager, Claims	
Contract A.07(b)	23. *Reporting and Analytics Staff: Ensures timely and accurate reporting and analytics needed to meet the requirements of the Contract.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Analyst, Reporting & Analytics; Analyst, Provider Configuration; Sr Analyst, HEDIS/Quality Reporting; Actuarial Analyst; Sr Analyst, Business; Analyst, Operational Regulatory Oversight	
Contract A.07(b)	24. *Quality Management Staff: Performs quality management and improvement activities.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Manager, Quality; EPSDT Coordinator; Sr Specialist, Quality Interventions/QI Compliance; Specialist, Quality Interventions/QI Compliance; Analyst, Quality Interventions/QI Compliance	
Contract A.07(b)	25. *Marketing and Outreach Staff: Manages marketing and outreach efforts.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Sr Specialist, Growth & Comm Engagement; Manager, SDOH; Manager, Materials Communication	

Standard XIV—Staffing Checklist		
Reference	**Required Components**	
Contract A.07(b)	26. *Compliance Staff: Supports the Compliance Officer and ensures compliance with laws and regulations, internal policies and procedures, and terms of the Contract.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Auditor, Compliance; AVP, Compliance; Sr Auditor, Vendor Management	
Contract A.07(b)	27. *Community-Based Case Managers: Ensures member needs are met, manages resources effectively, and ensures members' health, safety, and welfare are met. Assists the members in gaining access to appropriate resources. Recommend staff have bachelor's degree in social work or related field or commensurate experience and experience with the Iowa Medicaid program.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Case Manager and Case Manager (RN)	
Contract A.07(b)	28. *SIU Staffing (one [1] full-time Iowa-dedicated SIU staff member for each 100,000 members assigned to the MCO and a majority of SIU staff members located in Iowa): Reviews, investigates, and audits the MCO's providers and members to identify fraud, waste, and abuse.*	Y ☒ N ☐
	Evidence as submitted by the MCO: • RRQ_Attachment 7_Org_ Operational Areas • Iowa HSAG- Staffing Checklist- JD's • Key Personnel Table • Analyst, SIU; Investigator SIU; Manager Special Investigative Unit	

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Certification		
1. Documentation or information the MCO submits to HHS is certified by the MCO's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. a. The certification provided by the individual must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in §438.604 is accurate, complete, and truthful. b. The MCO submits the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b). 42 CFR §438.604(a-b) 42 CFR §438.606 Contract I.2.11	**HSAG Required Evidence:** • Policies and procedures, including processes to certify monthly program integrity reports (PI1–7, PI14) • Position of individual responsible for certification **Evidence as Submitted by the MCO:** • IA_GC-02 Monthly Report Certification Process • IA_ MHIA Certification of Data Submission	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") complies with requirements in 42 CFR §438.604(a-b) and 42 CFR §438.606 and Iowa Medicaid's monthly program integrity reports through the process outlined in IA_GC-02 Monthly Report Certification Process and by signing and attaching MHIA Certification of Data Submission as part of those submissions. Molina Healthcare, Iowa's VP of Government Contracts, is the position responsible for certification.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Compliance Program/Program Integrity Plan		
2. The MCO develops a compliance program that includes: a. Written policies, procedures, and standards of conduct that articulate the MCO or subcontractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements. b. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors. c. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract. d. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees, for the Federal and State standards and requirements under the Contract. e. Effective lines of communication between the compliance officer and the organization's employees. f. Enforcement of standards through well-publicized disciplinary guidelines. g. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan • Program Integrity (PI) Annual Work Plan • Organizational chart • Regulatory Compliance Committee charter • Compliance training materials • Training tracking mechanisms **Evidence as Submitted by the MCO:** a. IA_MHI Code of Business Conduct and Ethics, entire document b, IA_C-01.2 Compliance Officer, Compliance Committee and High - Level Oversight, II. Procedure, 1, page 1 c. IA_C-01.2 Compliance Officer, Compliance Committee and High - Level Oversight, II. Procedure, 2, page 1 c. IA _Regulatory Compliance Committee Charter (Iowa), entire document d. IA_C-01.3 Effective Training and Education, entire document d. IA _iLearn -screenshot d. IA_ Compliance Program Training 2022, entire document e. IA_ C-01.4 Effective Lines of Communication, entire document e. IA_ Program Integrity Org. Chart f. IA_ C-01.5 Well-Publicized Disciplinary Standards, entire document g. IA_ C-01.6 Routine Monitoring, Auditing, and Identification of Compliance, entire document h. IA_ MHIA PI13 PI Compliance Plan, entire document i. IA_ Program Integrity Work Plan, entire document j. IA_ MHIA PI13 PI Compliance Plan, pp. 19-20	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
the potential for recurrence, and ongoing compliance with the requirements under the Contract. h. *Preparing an annual compliance plan on the date identified by HHS, including the information requested and identified in the most current "Program Integrity Compliance Plan" template.* i. *Preparing an annual workplan on the date identified by HHS, including the information requested and identified in the most current "PI Annual Work Plan" template.* j. *Complying with annual, quarterly, and monthly requirements outlined under Contract section I.5.02 – I.5.05.* 42 CFR §438.608(a)(1) Contract I.5.01(a-i) Contract I.5.02–I.5.05		
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (a) (1) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Overpayments and Treatment of Recoveries		
3. The MCO implements and maintains arrangements or procedures for the prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to HHS. 42 CFR §438.608(a)(2) Contract I.5.02	**HSAG Required Evidence:** • Policies and procedures, including timeline for prompt reporting of overpayments • Special investigations unit (SIU) workflows • Identification mechanisms • Reporting mechanisms • Provider materials, such as the provider manual and provider contract **Evidence as Submitted by the MCO:** • IA_MHI-SIU 102 Opening and Conducting Investigations, Iowa Appendix 8, pg. 36	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	• IA_MHIA PI13 PI Compliance Plan, pg. 20-21 • IA_PI-REC-001- Overpayment Recoveries and Reporting, entire document • IA_PI-OVP-REP-001 Overpayment Reporting Procedure, entire document • IA_ Provider Manual, pg.119	
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (a) (2) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
4. The MCO follows the retention policies for the treatment of recoveries of all overpayments from the MCO to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. a. The MCO complies with the process, time frames, and documentation required for reporting the recovery of all overpayments. b. The MCO complies with the process, time frames, and documentation HHS requires for payment of recoveries of overpayments to HHS in situations where the MCO is not permitted to retain some or all of the recoveries of overpayments. c. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations. d. *Except as otherwise provided in the Contract, the MCO recovers improper payments and overpayments attributable to claims paid by the MCO, whether identified by the MCO or HHS, for five (5) years following the date the claim was paid.*	**HSAG Required Evidence:** • Policies and procedures • Overpayment tracking mechanisms • Provider materials, such as the provider manual and provider contract **Evidence as Submitted by the MCO:** • IA_MHI-REC-030 Claims Recovery, pages 11& 12 • IA_PI-REC-001- Overpayment Recoveries and Reporting, entire document • IA_PI-OVP-REP-001 Overpayment Reporting Procedure, page 2 • IA_ Provider Manual, pg. 119 • IA _Overpayment Tracking Mechanism, Screenshot • IA _Overpayment Letter Template	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
e. *Except as otherwise provided in the Contract, the MCO may recoup and retain overpayments attributable to claims paid by the MCO.* f. *Where a provider overpayment owed to the MCO is recovered by the Recovery Audit Contractor (RAC), HHS, or the federal government, by any means, including, but not limited to false claims act lawsuits and investigations or any other State or federal action or investigation, the MCO is not entitled to recoup, retain, or be reimbursed for any such overpayment. HHS determines, in its sole discretion, if any portion of the recovered payment over which HHS has authority will be returned to the MCO.* 42 CFR §438.608(d)(1) Contract I.8.01–I.8.05		
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (d) (1) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** After the site review, the MCO provided its MHI-SIU-102 Opening and Conducting Investigations policy that included language to support the MCO will submit and obtain approval from the Iowa Medicaid Program Integrity Unit prior to initiating any recoupment or withhold of overpaid funds. Because the MCO is confirming that this step will occur prior to recovering any overpayments from its contracted providers, HSAG determined this element as *Met*. However, HSAG strongly recommends that the MCO update its policies and procedures related to recoveries to specifically include the language under sub-element (f) so it is clear that when a provider overpayment owed to the MCO is recovered by the Recovery Audit Contractor, HHS, or the federal government, the MCO is not entitled to recoup, retain, or be reimbursed for any such overpayment.		
Required Actions: None.		
5. The MCO requires and has a mechanism for a network provider to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.	**HSAG Required Evidence:** • Policies and procedures • Overpayment and monitoring mechanisms • Provider materials, such as the provider manual and provider contract	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.608(d)(2) Contract I.10.01	**Evidence as Submitted by the MCO:** • IA_MHI-REC-030 Claims Recovery, page 3 • IA_PI-REC-001 Overpayment Recoveries and Reporting, entire document • IA_PI-OVP-REP-001 Overpayment Reporting Procedure, entire document • IA _Molina Iowa HSA (FFS), page 9 • IA_ Provider Manual, page 119 • IA _Overpayment Letter Template	
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (d) (2) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Notification of Member and Provider Changes		
6. The MCO (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between HHS and the MCO) implements and maintains arrangements or procedures for prompt notification to HHS when it receives information about changes in a member's circumstances that may affect the member's eligibility including all of the following: a. Changes in the members residence; b. The death of an enrollee. 42 CFR §438.608(a)(3) Contract I.11.03	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** • IA_ CR 04-06-OGM-SSA Death Master File Procedure, entire document • IA_ MHI-EA-299 Deceased Member, entire document • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, pg. 12	☒ Met ☐ Not Met
MCO Description of Process: As of February 2023, Molina Healthcare of Iowa (Molina) has not been instructed on how Iowa Health and Human Services wants to be notified regarding a member's change of residence. Molina educates members through the Molina Healthcare of Iowa Member handbook that they need to notify the state of any changes in their residence promptly.		

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** The MCO provided evidence to support it will notify HHS of deceased members. The MCO also confirmed through the member handbook that it requires members to contact the Iowa HHS Income Maintenance Customer Call Center or Hawki Member Services and the MCO if the member moves. However, the MCO stated that it has not been instructed on how HHS wants to be notified regarding a member's change of residence that may affect member eligibility. HSAG received guidance from HHS that the MCO can provide address update changes through the HHS Iowa Medicaid Portal Access (IMPA) system if a member makes the MCO aware of changes. During the coronavirus disease 2019 (COVID-19) unwind period (until March 2024), HHS will update addresses in the eligibility systems based on information provided by the MCO. After March 2024, MCO address changes will have to be validated by HHS prior to making changes to the eligibility systems; some exceptions will apply. All changes to an out-of-state address and some child welfare cases need to be referred to the HHS Contact Center to update the information. IMPA directs the MCO to contact the HHS Contact Center for all exceptions. As such, HSAG recommends the MCO update its policies, procedures, and staff training in accordance with HHS' guidance.		
Required Actions: None.		
7. The MCO (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between HHS and the MCO) implements and maintains arrangements or procedures for notification to HHS when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO. 42 CFR §438.608(a)(4) Contract I.11.04	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** • IA_PS-53 Provider Termination Process Policy, entire document • IA_PS-53 Provider Termination Process Procedure, entire document • IA_PCM Notice of License Sanction etc. • IA_PCP Termination Notice Template	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (a) (4) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Verification of Services Provided		
8. The MCO (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between HHS and the MCO) implements and maintains arrangements or procedures for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis. 42 CFR §438.608(a)(5) Contract I.12.01	**HSAG Required Evidence:** • Policies and procedures • Plan to initiate verification of services activities • Methodology for verifying services **Evidence as Submitted by the MCO:** • IA_C-01.9_ Verification of Services, entire document • IA_MHIA PI13 PI Compliance Plan, pg. 23 • IA_ Program Integrity Work Plan	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (a) (5) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Whistleblower Protection		
9. In the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, the MCO (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between HHS and the MCO) implements and maintains arrangements or procedures, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCO:** • IA_ DRA Section 6032 Healthcare Entity Oversight Policy, entire document • IA_DRA Letter and Attestation (example) • IA_C-01.0_ Compliance Program, pg. 2 • IA_C-01.3_Effective Training and Education, entire document • IA_C-01.4_Effective Lines of Communication, pg. 3 • IA_MHI Code of Business Conduct and Ethics, pg. 9	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.608(a)(6) Contract I.12.04	• IA_ Compliance Program Training 2022 • IA_ Fraud, Waste, and Abuse – General Training 2022 • IA _Iowa Vendor Addendum 10.20.2022, pg. 4	
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608(a)(6) as evidenced in the information submitted for this review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Fraud, Waste, and Abuse		
10. The MCO (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between HHS and the MCO) implements and maintains arrangements or procedures: a. That are designed to detect and prevent fraud, waste, and abuse. b. For the prompt referral of any potential fraud, waste, or abuse that the MCO identifies to HHS' program integrity unit or any potential fraud directly to HHS' Medicaid Fraud Control Unit (MFCU). 42 CFR §438.608(a) 42 CFR §438.608(a)(7) Contract I.5.01 Contract I.12.07	**HSAG Required Evidence:** • Policies and procedures • SIU workflow • Reporting mechanisms **Evidence as Submitted by the MCO:** • IA_C-01.0 Compliance Program, entire document • IA_MHIA-SIU-102 Opening and Conducting Investigations Procedure, entire document • IA_MHI-SIU-101 Administrative Action Procedure, pages 1 & 16-17 • IA_C-01.4 Effective Lines of Communication, entire document • IA _Iowa Vendor Addendum 10.20.2022, pages 7-8	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608(a), 438.608(a)(7) and the Iowa Health Link contract as evidenced in the information submitted for this review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
11. *The MCO conducts regular review and audits of operations, including incorporation of Correct Coding Initiative editing in the MCO's claims adjudication process.* a. *The MCO assesses and strengthens internal controls to ensure claims are submitted and paid properly.* b. *The MCO ensures sufficient organizational resources to effectively respond to complaints of fraud and abuse and shall effectively and efficiently respond to complaints of fraud and abuse.* c. *The MCO develops data mining techniques and conduct on-site audits.* 42 CFR §438.608(a) Contract I.12.01–I.12.03 Contract I.12.05–I.12.06	**HSAG Required Evidence:** • Policies and procedures • Plan to initiate audits • Audit methodology • Internal controls for claims payment • Organizational chart • Fraud and abuse complaint reporting mechanisms • Fraud and abuse data mining mechanisms **Evidence as Submitted by the MCO:** • IA_C-01.6 Routine Monitoring, Auditing, and Identification of Compliance Risks, entire document • IA_MHI.CLMS.07 Claims Quality Audit Policy, entire document • IA_MHI.CLMS.13 Claims Inventory Management Policy, entire document • IA_MHI-CLM-018 Claims Audit Unit Overview, entire document • IA_ Program Integrity Org. Chart • IA_ RRQ_ Attachment 8_Staffing Plan, pg. 3	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (a) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Suspension of Payments		
12. The MCO, and all applicable subcontractors, implements and maintains arrangements or procedures for the suspension of payments to a network provider for which HHS determines there is a credible allegation of fraud in accordance with 42 CFR §455.23. 42 CFR §438.608(a)(8) 42 CFR §455.23 Contract I.13.01	**HSAG Required Evidence:** • Policies and procedures • Payment suspension workflow **Evidence as Submitted by the MCO:** • IA_MHI-SIU-101 Administrative Action Procedure, pages 1 & 16-17 • IA_GC-01 Subcontractors Policy, page 2 • IA _Iowa Vendor Addendum 10.20.2022, pages 7-8 • IA_ Payment Suspension Workflow	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (a)(8) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** As determined through ongoing discussions with the HHS program integrity team, the MCO should update the Iowa appendix within its Administrative Action procedure to outline all state-specific expectations related to the reporting of fraud, waste, and abuse and the process for suspending payments to contracted providers.		
Required Actions: None.		
13. The MCO, and all applicable subcontractors, issues a notice of payment suspension that comports with 42 CFR §455.23 and retains the suspension for the time designated in that provision, the MCO maintains all materials related to payments suspension for five (5) years as required by 42 CFR §455.23(g). a. The MCO provides a grievance process for providers whose payments have been suspended under this provision. b. When notified that the HHS suspension has been lifted, the MCO, and all applicable subcontractors, lifts its suspension of payments and return the suspended payments to the provider unless the MCO has other authority to continue to withhold those payments.	**HSAG Required Evidence:** • Policies and procedures • Payment suspension workflow • Notice of payment suspension letter template **Evidence as Submitted by the MCO:** • IA_CR01 Credentialing and Reredentialing Practitioners Procedure, V, 2, a), page 43 • IA_MHI-SIU-101 Administrative Action Procedure, pages 1 & 16-17 • IA_SOP Suspension Termination or Other Actions • IA_ Payment Suspension Workflow	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.608(a)(8) 42 CFR §455.23 Contract I.13.02–I.13.03	• IA_ Notice of Payment Suspension- Draft • IA _Iowa Vendor Addendum 10.20.2022, Pages 7-8	
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (a)(8), 42 CFR 455.23, and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. Of note, HSAG confirmed when HHS takes an adverse action to suspend a provider from receiving payment or participation in Iowa Medicaid programs, HHS notifies the provider and provides the MCO with a copy of the notice, and the MCO is required to reciprocate the State's actions and communicate its actions against its network provider by sending notice to the provider notifying them of the State's actions. The provider notice must include its intended action to reciprocate the State's action and the provider's ability to file a grievance against the MCO's action to reciprocate. If the provider wishes to appeal the State's action, the MCO may direct the provider to file an appeal with the State by following the direction on the notice of suspension sent by the State. The template letter provided after the site review met the intent of this process.		
Required Actions: None.		
Provider Screening and Enrollment Requirements		
14. The MCO ensures that all network providers are enrolled with HHS as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of part 455, subparts B and E. 42 CFR §438.608(b) Contract I.2.17	**HSAG Required Evidence:** • Policies and procedures • Medicaid enrollment verification workflow • Two examples of documented Medicaid enrollment verifications **Evidence as Submitted by the MCO:** • IA_ Provider Integrity Provider Screening, entire document • IA_ Provider Enrollment Examples	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (b) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element. **Recommendations:** Although the MCO provided evidence to support that it has a process for confirming provider enrollment, HSAG recommends that all related policies and procedures are updated to include the department(s) responsible for the initial review (e.g., contracting department, credentialing department) and also the department(s) responsible for ongoing monitoring to ensure network providers remain actively enrolled with HHS.		

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
15. The MCO may execute network provider agreements *with nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IDs) undergoing a change in ownership and* pending the outcome of screening and enrollment of up to one hundred and twenty (120) days. a. *As to all other providers*, the MCO may execute network provider agreements pending the outcome of screening, enrollment, and revalidation of up to one hundred and twenty (120) days. b. *In either circumstance*, the MCO terminates a network provider immediately upon notification from HHS that the network provider cannot be enrolled, or the expiration of the one hundred and twenty (120) day period without enrollment of the provider and notify affected members. 42 CFR §438.602(b)(2) Contract I.11.02	**HSAG Required Evidence:** • Policies and procedures • Medicaid enrollment timeliness tracking mechanisms **Evidence as Submitted by the MCO:** • IA_ MHI NSS 2a, pg. 3 • IA_SOP Contracting Process Credentialing Workflow	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 438.608 (b)(2) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Disclosures and Prohibited Affiliations		
16. The MCO, and any subcontractors: a. Provides written disclosure of any prohibited affiliation under 42 CFR §438.610. b. Provides written disclosures of information on ownership and control required under 42 CFR §455.104. c. Reports to HHS within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. 42 CFR §455.104 42 CFR §438.608(c) 42 CFR §438.610 Contract I.2.12–I.2.18	**HSAG Required Evidence:** • Policies and procedures • Provider contract template • Disclosure of ownership and control notice template - **Evidence as Submitted by the MCO:** • IA_C-03.0_Prohibited Affiliations, entire document • IA_C-03.1_Prohibited Affiliations Procedure, page 3 • IA_C-04.0_Written Disclosure, II Policy, A, page 1 • IA_ Molina Iowa HSA (FFS), pp. 7 & 8 • IA_4_Ownership Control and Disclosure Form	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 455.104, 438.608 (c), 438.610 and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Provider Disclosures/Provider Applications for Program Integrity Reasons		
17. *The MCO implements in its provider enrollment processes the obligation of providers to disclose the identity of any person described in 42 CFR §1001.1001(a)(1) as well as other permissible exclusions that would impact the integrity of the provider enrollment.* a. *The MCO forwards such disclosures to HHS.* b. *The MCO abides by any direction provided by HHS on whether or not to permit the applicant to be a provider in the program.*	**HSAG Required Evidence:** • Policies and procedures • Provider contract template • Disclosure of ownership and control notice template • Reporting mechanisms **Evidence as Submitted by the MCO:** • IA_C-03.0 Prohibited Affiliations, entire document • IA_C-04.0 Written Disclosures, entire document • IA_Ongoing Monitoring Policy, pages 1 & 2	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
i. *Specifically, the MCO does not permit the provider to become a network provider if HHS or the MCO determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services program, or if HHS or the MCO determines that the provider did not fully and accurately make any disclosure pursuant to 42 CFR §1001.1001(a)(1).* Contract I.11.06	• IA_State Addendum, page 3 • IA_ Ownership Control Disclosure, entire document • IA_ Molina Iowa PSA (FFS), pg.8	
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR 1001.1001(a)(l) and the Iowa Health Link Contract as evidenced by the information submitted for review.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Coordination and Program Integrity Efforts		
18. *The MCO assures coordination efforts with HHS and other agencies with regards to program integrity issues.* Contract A.07(e)(16)	**HSAG Required Evidence:** • Policies and procedures • Compliance plan • Organizational chart • Job description(s) **Evidence as Submitted by the MCO:** • IA _Iowa Program Integrity Org. Chart • IA_SIU Job Aid _CRLEA, entire document • IA_MHIA P13 PI Compliance Plan, pg. 6 • IA_JD-Mgr., SIU_PI • IA_JD-Investigator. SIU • IA_JD-Analyst, SIU	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa is currently in the process of hiring program integrity staff in compliance with A.07 (e) (16) of the Iowa Health Link contract.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		
Reporting Obligations for Adverse Actions Taken on a Provider		
19. *The MCO notifies HHS and the Office of the Inspector General (OIG) of provider decredentialing for program integrity reasons and in compliance with 42 CFR Part 1001.* 42 CFR Part 1001 Contract I.11.06	**HSAG Required Evidence:** • Policies and procedures • Compliance plan • Identification and reporting mechanisms **Evidence as Submitted by the MCO:** • IA_ CR 04 Ongoing Monitoring Policy, entire document • IA_ CR 04.01 OGM- Sanctions Monitoring Procedure, entire document • IA_MHIA PI13 PI Compliance Plan, pp. 19 & 25	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa complies with 42 CFR Part 1001 as evidenced in the information submitted for this element.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XV—Program Integrity						
Met	=	19	X	1	=	19
Not Met	=	0	X	0	=	0
Total	=	19	**Total Score**		=	19
				Total Score ÷ Total	=	100%

Appendix B. Operational Readiness Review Remediation Plan

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Electronic Materials and Communications		
24. *The MCO leverages technology to promote timely, effective, and secure communications with members.* a. *Once a member selects a communication pathway, the MCO confirms that choice through regular mail with instructions on how to change the selection if desired.* b. *The MCO maintains the means to receive communication from members electronically, including via mail and website.* c. *The MCO responds to electronic inquiries within one (1) business day.* d. *The MCO is encouraged to utilize mobile technology, such as electronic delivery of medication and appointment reminders.* Contract C.8.02	**HSAG Required Evidence:** • Policies and procedures • Member materials with information on the modes by which members can communicate with the MCO • Mechanism for tracking members' preferred communication pathway (e.g., screenshot of system) • Screenshot of the messaging option on the member website • Mobile application workflows (e.g., text message reminders) • Staff training materials **Evidence as Submitted by the MCO:** • IA_ME.01-Member Communication Policy pg. 4 Section M. • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023 pg. 3 Welcome and pg. 4. Important Contact Information • IA Mobile application workflows. Entire document. • IA_Mechanism Mem Communication Pathway-_Messaging. Entire document. • Staff training is under development and will include the Member Communications Policy.	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa uses mobile technology to communicate with members. Such communication includes mobile applications and secure messaging.		
HSAG Findings: Although the MCO provided a demonstration of its member portal in the testing environment, the MCO indicated that the member portal will not be in production until June 2023.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Provide confirmation that the Iowa member portal is in production.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa confirms that the Iowa member portal will be in production by June 15, 2023. Molina will provide confirmation to HSAG of live production status.		
Individual(s) Responsible: Michael Wharton and Jeff Cangialosi		
Completion Date: 6/15/23		
HSAG Feedback: The MCO's remediation plan is sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		

1. The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.
 	
42 CFR §438.206(b)(1)
Contract E.1.05
Contract E.1.21
	HSAG Required Evidence:
	• Policies and procedures
	• Provider materials, such as the provider manual
	• Copy of each type of provider contract template, including ancillary, hospital, and individual/group
	• Provider Network Onboarding Plan (as requested in the MCO Questionnaire)
	• Network adequacy analyses, such as GeoAccess mapping
	• Staff training materials
	
	Evidence as Submitted by the MCO:
	• MHI NSS – 2 Availability of Services and Adequate Capacity Procedure pg 1 II. (b) (1)
	• MHI NSS – 1.3 Network Accessibility & Adequacy Procedure pg 2 and 3
	• IA MW2-30 Network Provider Listing Medical Sample Provider File tab 2 “Data Feed”
	• Iowa Network Adequacy Reports by Region
	• IA Provider Manual 020923 page 16-17, 70, 141, 147
	• Confirmed copies of each contract template include:
	  − Molina Iowa HCBS (Home and Community Based Services)
	  − MolinaIowa HSA (Hospital Services Agreement)
	  − Molina Iowa PSA (Provider Services Agreement)
	• IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL, pg 1
		☐ Met
		☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• Iowa Provider Services Employee Staff Training 2023 Final - Slide 75	
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") has provided the following evidence for this element that includes two procedures, referenced pages within our Provider Manual, provided copies of each provider contract type requested, including the relevant portion of our Provider Network Onboarding plan that also includes Geo Access mapping. Lastly, we provided the relevant portion of our IA Provider Services Staff Training Deck to provide training content to our Provider Services team.		
HSAG Findings: Although the MCO has made progress in recruiting and contracting with providers, gaps remain for hospitals, specialty providers (i.e., pediatrics), behavioral health (i.e., pediatric/adolescent substance abuse), and Home- and Community-Based Services (HCBS)/LTSS providers. During the site review, MCO staff members described their comprehensive plan for continued development of the MCO's network and indicated they would enter into single case agreements (SCAs) as necessary. MCO staff members also explained that the MCO is close to finalizing contracts with two large healthcare systems which will close some of the identified provider gaps.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Demonstrate that significant progress has been made toward achieving an adequate network with an appropriate range of providers to serve members assigned to the MCO. • Submit network adequacy reports routinely that demonstrate progress and include, at a minimum, provider counts by provider type and a time and distance analysis once the MCO receives an enrollment file from HHS.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa has made significant progress through the finalization of contracts with all large healthcare systems and will continue our efforts to bolster our Network. Molina will continue to submit updated network adequacy reports on a bi-weekly basis that show significant progress towards achieving an adequate network with an appropriate range of providers to serve members and we will achieve network adequacy by the final report due to HSAG on June 23, 2023. We have uploaded to SAFE on May 25th, 2023 our most recent "IA Network Adequacy 05 25 23" and "HSAG Report 05 25 23" reports.		
Individual(s) Responsible: Tom Newton		
Completion Date: 6/23/23		
HSAG Feedback: The MCO's remediation plan, contingency plan, and supporting documentation are sufficient to ensure readiness with the requirements for this program area. However, the MCO will be required to submit weekly network adequacy reports to HHS and HSAG to provide continued assurances that the network is sufficient to support timely access to care and services for the MCO's enrolled members on and after July 1, 2023. Additionally, the MCO must continue to expand its network based on the ongoing changes in membership needs.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
3. The MCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. 42 CFR §438.206(b)(7) Contract E.1.23	**HSAG Required Evidence:** • Policies and procedures • Provider Network Onboarding Plan (as requested in the MCO Questionnaire) • Network adequacy analyses, such as GeoAccess mapping • List of provider types designated as family planning providers **Evidence as Submitted by the MCO:** • MHI NSS – 2 Availability of Services and Adequate Capacity Procedure pg 1 II. (b) (7) • IA MW2-30 Network Provider Listing Medical Sample Provider File tab 2 "Data Feed" *Search "Family Planning" and see examples: rows 679, 833, etc.* • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL pg 1 • Iowa Provider Services Employee Staff Training 2023 Final - Slide 76 • Iowa – for Standard IV Availability of Services Family Planning Provider Types	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa has provided the following evidence for this element that includes our procedures, our Provider Network Onboarding plan that also includes Geo Access mapping. We have also included the element in our staff training deck for our provider services team. Lastly, we provided a list of family planning providers via provider type 22 that we are currently recruiting to become in-network providers by location.		
HSAG Findings: Although the MCO has made progress in recruiting and contracting with providers, sufficient evidence was not provided to demonstrate the MCO has an adequate network of family planning providers. During the site review, MCO staff members described their comprehensive plan for		

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
continued development of the MCO's network and indicated they would enter into SCAs as necessary. MCO staff members also explained that the MCO is close to finalizing contracts with two large healthcare systems which will close some of the identified provider gaps.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Demonstrate that significant progress has been made toward achieving an adequate network with an appropriate range of providers to serve members assigned to the MCO. • Submit network adequacy reports routinely that demonstrate progress and include, at a minimum, provider counts by provider type and a time and distance analysis once the MCO receives an enrollment file from HHS.		
Plan to Remedy Deficiency: In addition to being contracted with all large healthcare systems, Molina Healthcare of Iowa has made significant progress on family planning providers as we are now contracted with Planned Parenthood of Iowa. Molina will continue to submit updated network adequacy reports on a bi-weekly basis that show significant progress towards achieving an adequate network with an appropriate range of providers to serve members and achieve network adequacy by the final report due to HSAG on June 23, 2023. We have uploaded to SAFE on May 25th, 2023 our most recent "IA Network Adequacy 05 25 23" and "HSAG Report 05 25 23" reports.		
Individual(s) Responsible: Tom Newton		
Completion Date: 6/23/23		
HSAG Feedback: The MCO's remediation plan, contingency plan, and supporting documentation are sufficient to ensure readiness with the requirements for this program area. However, the MCO will be required to submit weekly network adequacy reports to HHS and HSAG to provide continued assurances that the network is sufficient to support timely access to care and services for the MCO's enrolled members on and after July 1, 2023. Additionally, the MCO must continue to expand its network based on the ongoing changes in membership needs.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard V—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Basic Rule		
1. The MCO gives assurances to HHS and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with HHS' standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). a. The MCO submits documentation to HHS, *as required by the Reporting Manual*, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. iii. *Ensures that the services can be furnished promptly and without compromising the quality of care.* b. *Demonstrates sufficient access to essential hospital services to serve the expected enrollment.* 42 CFR §438.207(a); (b)(1-2) Contract E.1.01(b) Contract E.1.11 Contract E.1.24 Contract E.1.26-E.1.27 Contract Exhibit C: General Access Standards	**HSAG Required Evidence:** • Policies and procedures • Provider Network Onboarding Plan (as requested via the Questionnaire) • Plan for network adequacy monitoring • Network adequacy reports/analyses (i.e., provider network and performance target reports, including the projected number of providers required for each provider type and contracting status) • Staff training materials • HSAG will also use the results of the Access Standards: Time/Distance Checklist **Evidence as Submitted by the MCO:** • MHI NSS 1.3 Network Accessibility and Adequacy Procedure – Medicaid.docx - pgs 1-4 • IA 2022 MHI NSS 1.3a Network Accessibility & Adequacy State Addendum – Provider Network.docx - pgs 1-3 • MW2-30 Network Provider Listing Medical Sample Provider File.xlsx Tab 2 Data Feed and Rural vs Urban tab • Iowa Network Adequacy Reports by Region – entire document • IA MCO RR Questionnaire 10. Provider Network Onboarding Plan FINAL.docx - Pg 2 and 8-9 • Iowa Provider Services Employee Staff Training 2023 Final.pptx -slide 84	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard V—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina Healthcare of Iowa, Inc. ("Molina Healthcare of Iowa") has outlined this element within our Network Accessibility and Adequacy Procedure as well as State Addendum. We've also supplied our Network Provider Listing Sample excel spreadsheet by provider type, time and distance, rural vs urban. We have also outlined this in our Provider Network Onboarding Plan. These documents including content in our Staff Training Deck will be used for training purposes.		
HSAG Findings: Although the MCO had made progress in recruiting and contracting with providers, gaps remain for hospitals, specialty providers (i.e., pediatrics), behavioral health (i.e., pediatric/adolescent substance abuse), and HCBS/LTSS providers. During the site review, MCO staff members described their comprehensive plan for continued development of the MCO's network and indicated they would enter into SCAs as necessary. MCO staff members also explained that the MCO is close to finalizing contracts with two large healthcare systems which will close some of the identified provider gaps.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Demonstrate that significant progress has been made toward achieving an adequate network with an appropriate range of providers to serve members assigned to the MCO. • Submit network adequacy reports routinely that include, at a minimum, provider counts by provider type and a time and distance analysis once the MCO receives an enrollment file from HHS.		
Plan to Remedy Deficiency: Since finalizing contracts with all large healthcare systems in May, Molina Healthcare of Iowa has prioritized contracting with remaining hospitals, specialty providers, behavioral health, and HCBS/LTSS providers, which will close identified adequacy gaps in selected regions and counties. Molina will continue to submit updated network adequacy reports on a bi-weekly basis that show significant progress towards achieving an adequate network with an appropriate range of providers to serve members and achieve network adequacy by the final report due to HSAG on June 23, 2023. We have uploaded to SAFE on May 25th, 2023 our most recent "IA Network Adequacy 05 25 23" and "HSAG Report 05 25 23" reports.		
Individual(s) Responsible: Tom Newton		
Completion Date: 6/23/23		
HSAG Feedback: The MCO's remediation plan, contingency plan, and supporting documentation are sufficient to ensure readiness with the requirements for this program area. However, the MCO will be required to submit weekly network adequacy reports to HHS and HSAG to provide continued assurances that the network is sufficient to support timely access to care and services for the MCO's enrolled members on and after July 1, 2023. Additionally, the MCO must continue to expand its network based on the ongoing changes in membership needs.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
State Care Coordination Program Requirements		
13. The MCO complies with all HHS-required care coordination program requirements as specified in the Care Coordination Checklist. Contract G.2	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Initial health risk screening tool template • Initial health risk screening tracking and monitoring mechanisms • Comprehensive health risk assessment tool template • Comprehensive assessment tracking and monitoring mechanisms • Risk stratification methodology (i.e., risk level assignments) • Care plan template • Method(s) of disseminating care plan to PCP, other providers, and members • Care plan tracking and monitoring mechanisms • Member outcomes tracking and reporting mechanisms • Method(s) of sharing care coordination information with the member, authorized representatives, and relevant treatment providers • Method(s) for monitoring the effectiveness of the care coordination program • Process for reviewing and updating care plans • Staff training materials • HSAG will use the results of the Care Coordination Checklist • HSAG will also use the results of the system demonstration	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCO: • Care Coordination Checklist • IA_HRS Tool • IA_CMMT Initial Health Risk Screening tracking and monitoring screenshot • IA _Molina TCNA • IA _Molina FCNA • IA_CMMT Comprehensive Assessment Tracking and Monitoring screenshot • IA_HCS-151 • IA_HCS-151.01 • IA_CCA Care Plan Example screenshot • IA_HCS 154.01 • IA_CM-Risks Strat-Programmatic Levels PPT. • IA_ICP PPT.pdf • IA_CCA Assessments-HRA, Condition Specific, and Direct Referral • IA_2023 HCS Program Description, page 48 (Care Management description), page. 50 (risk strat), pages. 77-78 (Monitoring of CM program) • IA_ PCP Letter-Participating Mbr. • IA_ Medicaid Std. Care Plan Letter • IA_CMMT - Care Plan Report. • IA_ HCS-404 • IA_HCS- 404.01 • IA_LTSS New Hire Training Draft PPT, slide 32 • IA_ HCS-405 HCS	

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• IA _Annual and Five-Year Quality HCS Work Plan Draft, page 78	
MCO Description of Process: Molina Healthcare of Iowa complies with all HHS-required care coordination program requirements as specified in the Care Coordination Checklist.		
HSAG Findings: Although the MCO provided a demonstration of its Iowa-specific member and provider portals, the portals will not be in production until June 2023. Of note, while the MCO did not provide documentation that confirmed it would conduct an initial health risk screening (HRS) for members who have not been enrolled in the prior 12 months, MCO staff members clarified that they will conduct an HRS on all newly enrolled members regardless of whether a member was disenrolled and reenrolled. As this process is more stringent than contract, this finding was not identified as a deficiency (Care Coordination Checklist—Element 1). **Recommendations:** HSAG recommends the following related to the Care Coordination Checklist elements: • Element 2—The telephonic HRS included a section to document if the member was offered assistance with scheduling an initial primary care provider (PCP) appointment. While the response options for this section were *Yes* or *No*, MCO staff members clarified that if *No* was selected it indicated that it was not applicable (e.g., member already established care with a PCP). As such HSAG recommends the MCO consider updating the telephonic HRS template to indicate *Yes* or *Not Applicable* responses or ensure that the narrative section of the template includes an explanation should *No* be selected. • Elements 5 and 7—The MCO did not provide documentation supporting the 70 percent standard for completing HRSs. However, MCO staff members confirmed understanding of this standard and of the reporting obligations to HHS. As such, HSAG recommends that staff training include awareness of HHS' standard for completing HRSs. • Element 12—The MCO did not have a defined standard for a communication plan with providers; however, MCO staff members explained that outreach to providers would occur as needed and that any feedback would be incorporated into the care plan, as applicable. However, as care plans are required to include a communication plan with providers, HSAG recommends that the MCO ensure staff members are trained on this provision to ensure a provider communication plan is consistently documented within the care plan. • Element 18—While the HCS Program Description verified that the MCO will implement processes to evaluate the care management program, as the MCO is new to the Iowa Medicaid managed care program, HSAG recommends that the MCO implement close monitoring of its care management program and its care managers to ensure it implements all requirements effectively and to ensure it immediately remediates any identified concerns. Additionally, HSAG recommends that its formal care management evaluation process include a review of care management key performance indicators and a care management file review.		
Required Actions: In order to receive a *Met* score for this element, the MCO must:		

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
• Provide confirmation that the member and provider portals are live for the Iowa Medicaid managed care program.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa confirms that the member and provider portals will be live for the Iowa Medicaid managed care program in June. The member portal is set to deploy into the production environment by June 15, 2023, and the provider portal on June 17, 2023. Molina will provide confirmation to HSAG of live production status for both portals. Molina has reviewed the recommendations from HSAG for this element and are incorporating the following updates into our plan. • Element 2: Molina Healthcare of Iowa will update the answer selection for initial PCP appointment to yes or not applicable post July 1, 2023. • Elements 5 and 7: Case Managers have been fully trained on Iowa contractual requirements, but Molina Healthcare of Iowa will incorporate the recommendation of the completion of 70% of HRS's standard in additional training with all case managers prior to July 1, 2023. • Element 12 and 18: Molina Healthcare of Iowa has trained all Case Managers as of May 26th, 2023 on our plan requirement to document outreach to providers on a consistent basis, as well as during creation of the care plan. Molina Healthcare of Iowa audits five charts per case manager per month to ensure that Case Managers are outreaching to providers and incorporating their feedback into the care plan. Incorporation of provider input in each care plan is one of the areas included in the monthly audit of files. Additionally, providers are invited to participate in the care plan meeting with the member.		
Individual(s) Responsible: Michael Wharton and Jeff Cangialosi and Jill Villalobos for Care Coordination Recommendations		
Completion Date: 6/17/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Transition/Continuity of Care		
15. During the first year following the MCO's entry into IA Health Link, with the exception of LTSS, residential services, and certain services rendered to dual diagnosis populations, the MCO honors all existing authorizations for covered benefits for a minimum of ninety (90) days, without regard to whether such services are being provided by contracted or non-contracted providers, when a member transitions to the MCO from another source of coverage. a. *The MCO honors existing exceptions to policy granted by the Director for the scope and duration designated.* b. *At all other times, the MCO honors all existing authorizations for a minimum of thirty (30) days when a member transitions to the MCO from another source of coverage, without regard to whether services are being provided by contracted or non-contracted providers.* c. *The MCO has policies and procedures to identify existing prior authorizations at the time of enrollment.* d. *When a member transitions to another MCO, the MCO provides the receiving entity with information on any current service authorizations, utilization data, and other applicable clinical information such as disease management or care coordination notes.* e. *The MCO provides for the continuation of medically necessary covered services to newly enrolled members transitioning to the MCO's care regardless of prior authorization or referral requirements.*	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Member materials, such as the member handbook and welcome packet • Staff training materials • Mechanisms to ensure continuity of care and adherence to required time frames **Evidence as Submitted by the MCO:** • IA_HCS 407.01, II A.1.1, B.1-12 pages 1-2 • IA_2023 HCS Program Description. Page 88 • IA _Welcome Kit, zip folder • IA_MHC_Member-Handbook_Revised_State-and-HSAG_2023, page 20 • IA_ Combined Roles and CRP Detailed Agenda • IA_ CRC IP Role Specific NEO Agenda • IA_ CRC PA Role Specific NEO Agenda • IA_LTSS New Hire Training Draft PPT, slide 34	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Contract F.6.10-11 Contract F.16.09 Contract G.2.36 Contract G.3.09(h)		
MCO Description of Process: Molina Healthcare of Iowa ensures COC and access to care for members with existing providers, members receiving current treatments, and prior authorized services at the time of enrollment that fall within continuity of care guidelines and regulatory requirements. Molina will authorize and provide coverage for out of network providers, when necessary, services are not available within the network.		
HSAG Findings: While the draft new hire presentation for LTSS staff members included a topic on transitions, including reasons for transitions and information sharing, HSAG expected to see more thorough training on the initial transition of members effective July 1, 2023. After the site review, the MCO submitted staff training on discharge planning and transitions of care; however, it did not include staff training on the transition of care processes specific to the implementation of the MCO's Medicaid managed care program in Iowa nor the requirements of this element.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Submit staff training addressing all of the following: – Honoring all existing authorizations for, at a minimum, 90 days, regardless of whether services are provided by an in-network or out-of-network provider. – Honoring existing exceptions to policy. – Care management and utilization management responsibilities related to the receipt of member transfer records prior to July 1, 2023. – Care management responsibilities related to coordinating with the relinquishing MCO. – Care management responsibilities related to initiating initial contact with members, conducting assessments, and developing care plans/service plans. – Amount, duration, and scope of LTSS will not change unless a new level of care (LOC) assessment is completed (as stated by MCO staff members during the site review). – Provide confirmation that the MCO's system has been configured to pay claims regardless of prior authorization status and provider network status during the first 90 days of enrollment (as stated by MCO staff members during the site review and reiterated during the May 2023 system demonstration). Please note that this expectation applies to all newly enrolled members during the first year of the MCO's entry into the Iowa Medicaid managed care program and not only for the first 90 days after program implementation (e.g., if the MCO receives a newly enrolled member in August 2023, it must honor existing authorizations for the first 90 days of the member's enrollment date); therefore, the MCO must also submit its		

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
plan to ensure new members enrolled after July 1, 2023, will also have existing authorizations honored for the first 90 days of the member's enrollment. • Provide confirmation when member transfer records are received and data are entered into the MCO's system, including authorizations for LTSS members.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa has updated the continuity of care staff training, "Warm Hand Off Overview May 2023," to include honoring existing authorizations, exceptions to policies, and the roles and responsibilities of care management and utilization management teams. This updated training has been uploaded to SAFE. Molina can confirm our system has been configured to pay claims regardless of prior authorization or provider network status within the first 90 days of enrollment. This configuration will remain in effect for that first 90 days. A custom solution was created that will override authorization edits for 90 days based on a member's effective date. If there are any breaks in coverage, the 90-day override period will start over. Procedure "IA_ HCS 407.01" has been updated on page 2, Section B.8 to include our plan to ensure new members enrolled after July 1, 2023 will also have existing authorizations honored for the first 90 days. Molina received the first 834 file from HHS on May 26, 2023 and is in the process of uploading these files. Molina anticipates receiving Warm Hand Off files from other MCOs by June 10, 2023. Molina will utilize these files in a non-production environment due to the need to delete any records of individuals not included on the June 26, 2023 HHS file. Molina anticipates receiving 834 membership files from HHS on June 26, 2023, which will include all Molina members as of July 1, 2023. Relevant information from the MCO Warm Hand off files, including all authorizations, will be uploaded into Molina's production systems at that time. Molina will provide confirmation when we receive MCO Warm Hand off files, as well as when the final information has been uploaded into our systems after the June 26, 2023 membership file has been processed.		
Individual(s) Responsible: Brian Marston and (Staff Training) Matt Gunnon		
Completion Date: 6/26/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area. However, HSAG recommends when member transfer records are received that it prioritize the entry of the data into the MCO's systems, including authorizations for LTSS members. The MCO must provide HSAG with confirmation once the data have been successfully entered into its systems.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
16. During the first ninety (90) days following the MCO's entry into IA Health Link, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in Contract Section F.13.28, the MCO allows a member who is receiving covered benefits from a non-network provider at the time of MCO enrollment to continue accessing that provider, even if the network has been closed due to the MCO meeting the network access requirements. a. *The MCO is permitted to establish single case agreements with providers enrolled with Iowa Medicaid or otherwise authorize non-network care past the initial ninety (90) days of the contract to provide continuity of care for members receiving out-of-network services.* b. *The MCO makes commercially reasonable attempts to contract with providers from whom a member is receiving ongoing care.* c. *Out-of-network providers will be reimbursed a percentage of the network rate unless otherwise agreed upon through a single case agreement.* Contract G.2.37	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Member materials, such as the member handbook and welcome packet • Staff training materials • Single case agreement template • Continuity of care plan **Evidence as Submitted by the MCO:** • IA_HCS 407.01, II A-B, pages 1&2 • IA_ SCA Request Form.docx • IA_ Combined Roles and CRP Detailed Agenda • IA_ CRC IP Role Specific NEO Agenda • IA_ CRC PA Role Specific NEO Agenda • IA _MHC _Member- Handbook _Revised _State-and HSAG_2023 page 20-21 • IA_ HCS-391.01 IA HCS-391.01 Non-Participating Provider PA Requests Procedure_IA RR • IA_ SOP Single Case Agreement Final • IA_ Workflows for COC • IA_LTSS New Hire Training Draft PPT, slide 33	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa ensures COC and access to care for members with existing providers, members receiving current treatments, and prior authorized services at the time of enrollment that fall within continuity of care guidelines and regulatory requirements. Molina will authorize and provide coverage for out of network providers, when necessary, services are not available within the network.		
HSAG Findings: While the draft new hire presentation for LTSS staff members included a topic on transitions, including reasons for transitions and information sharing, HSAG expected to see more thorough training on the initial transition of members effective July 1, 2023. After the site review, the		

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCO submitted staff training on discharge planning and transitions of care; however, it did not appear to include staff training on the transition of care process specific to the implementation of the MCO's Medicaid managed care program in Iowa or include the requirements of this element.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Submit staff training addressing all of the following: – Allowing members to receive services from an out-of-network providers during the first 90 days of the MCO's entry into the Iowa Medicaid managed care program. – Care management responsibilities if a member is identified as receiving services from an out-of-network provider (e.g., notify provider network management to make attempts to contract with the provider). • Provide confirmation that the MCO has identified out-of-network providers via the member transfer records and is actively outreaching to those providers to become in-network providers or seeking an SCA.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa has updated our staff training on the continuity of care period, while also addressing the warm hand off process with other MCO's. This training includes specifics for members being allowed to receive services from an out of network provider during the first 90 days of Molina Healthcare of Iowa's entry into Iowa's Medicaid managed care program. In addition, the training also includes specifics on the responsibilities of the care manager when it is identified that a member is receiving services from an out -of -network provider. We have uploaded to SAFE the "Warm Hand Off Overview May 2023" training as evidence of compliance. Molina confirms that as of June 5, 2023, out-of-network providers, which are identified during the review of the warm hand off files (i.e., existing prior authorizations and PCP assignment), will be actively pursued for contracting and/or establishing a single case agreement, if appropriate, to facilitate member care.		
Individual(s) Responsible: Brian Marston, and (Staff Training) Matt Gunnon		
Completion Date: 6/5/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area. Of note, while the warm hand off of files to identify out-of-network providers has not yet occurred, the transfer of member files is being monitored through Element 15.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
1915(c) and 1915(i) Home- and Community-Based Services (HCBS)		
18. The MCO delivers HCBS services to all members meeting the eligibility criteria and authorized to be served by these programs. The MCO provides: a. *Screening of members who appear to be eligible;* b. *Timely completion of the initial and annual comprehensive functional assessment for needs-based eligibility and level of care;* c. *Monitoring of members on the HCBS wait list;* d. *Completion of a social history;* e. *Annual redetermination of needs-based eligibility and level of care;* f. *Service plan review, services monitoring, and authorization;* g. *Claims payment;* h. *Network capacity;* i. *Provider agreement execution;* j. *Rate setting; and* k. *Provider training and technical assistance.* Contract F.12B.01	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Level of care and functional assessment template(s) • Staff training materials • Provider training requirements • HCBS provider agreement template **Evidence as Submitted by the MCO:** • IA_HCS-501.01, page 2 Section B-9 • IA_HCS-505.01, page 3 Section T, W, X • IA_HCS-596.01, page 1 Purpose • IA_HCS-504.01, page 2 Section H • IA_HCS-507.01, page 1 Procedure in entirety • IA_ 2023 HCS Program Description, page 55 • IA_SPT Auth Example Screenshot • IA_LOCMS Workflow • IA_LOCMS Draft Training • IA_LOCMS QRG v3 • IA_LOC Assessment Process Flow • IA_LTSS CM Overview Workflow • IA_LTSS Facility Comp Asmt. • IA_PCSP Process Overview • IA_PCSP Template • IA _Waitlist Member Workflow **Level of Care Assessments – Configuration documents:**	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• IA_SIS-A Interview Form.2015 • IA_SIS-C Interview and Profile form • IA_470-4694 example • IA _InterRAI Peds HC 2014 V9.2.0 • IA _Mayo Portand Config. Document • IA _InterRAI HC V10 Config. Document • IA _InterRAI ChYMH Config Document • IA _InterRAI Adolescent Supplemental (ChYMH-A) v2 • IA_ Off Year Assessment Config Document • IA_Comp-Assess-and-SH-508.2 • IA_2350-MC-FFS_Asst._Tools • IA_LOC Annual Assessment Workflow • IA_LOC Reassessment Workflow • IA _Mockup Pending Assessment Report IA • IA_ Provider Manual 020923, pages 142-146 • IA _Molina Iowa HCBS PSA (FFS) • IA_LTSS New Hire Training Draft PPT, slide 49	
MCO Description of Process: Molina Healthcare of Iowa provides LTSS Care Management to all members who meet the eligibility criteria and are authorized to be served by these programs. The member has a level of care review, a comprehensive care management assessment and social history, development of a care plan and/or service plan and monitoring of service needs and authorization. The Agency has indicated the level of care and needs-based eligibility assessments that are to be used in the process.		
HSAG Findings: Although the MCO demonstrated its care management platform in the testing environment, the platform is not live for Iowa Medicaid managed care.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Submit the completed IA_LOCMS QRG and IA_LOCMS Draft Training documents.		

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
• Provide confirmation that the care management platform for the Iowa Medicaid managed care program is live.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa has completed the "IA LOCMS QRG 05242023" along with the "IA_LOCMS Training" document. The "IA LOCMS QRG 05242023" and "IA_LOCMS Training" documents have been uploaded to SAFE. Molina Healthcare of Iowa confirms that the CCA (care management platform) will be live June 15, 2023 and is also confirming the LOCMS platform went live in production on May 31, 2023. Molina will demonstrate LOCMS in live production on June 2, 2023 and CCA in live production on June 16, 2023.		
Individual(s) Responsible: (Care Management) Brian Marston, (Systems Platform) Michael Wharton and Jeff Cangialosi		
Completion Date: 6/15/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Utilization Management Program		
1. The MCO develops, operates, and maintains a utilization management (UM) program, which is documented in writing. a. *The UM program assigns responsibility to appropriate individuals, including a designated senior physician, and involves a designated behavioral healthcare practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program.* b. *The UM program contains UM strategies, including identification of criteria to be utilized by the plan.* c. *Notification of the MCO's UM strategies, including identification of criteria to be utilized by the plan, is provided to the provider community thirty (30) days prior to implementation or change.* Contract G.3.01	**HSAG Required Evidence:** • Policies and procedures • UM program description • Organizational chart • Job descriptions • Notice of UM criteria to providers Evidence as Submitted by the MCO: • IA HCS-364.01 Appropriate Professionals Making UM Decisions Procedure_IA RR page 2 • IA HCS-365.01 Clinical Criteria for UM Decision Making Procedure_IA RR page 4 • a IA HCS 2023 Program Description III.A. Governance. a page 8 • b IA HCS 2023 Program Description V. B. Review Criteria page 36 • c IA HCS 2023 Program Description page 88 • IA_RRQ Attachment 15 UM Org Chart.pptx – entire document • Chief Medical Officer Job Description – entire document • Vice President Healthcare Services Job Description – entire document • Director Healthcare Services Job Description – entire document • Manager Healthcare Services Job Description – entire document	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• Supervisor UM Care Review Job Description– entire document • UM Nurse CRC Job Description– entire document • Provider_Memo_Opioid_Benzo_Initial_Rx_Final508. Entire document. (Sample criteria Notice from Molina IL) • 2022_4th_Quarter_Provider_Newsletter_MHIL_Final508. Page 7 (Sample Newsletter criteria notice from Molina IL)	
MCO Description of Process: Molina Healthcare of Iowa, Inc.'s ("Molina Healthcare of Iowa") UM Program is overseen by our Chief Medical Officer, Dr. Timothy Gutshall in collaboration with our VP of Healthcare Services, VP of BH, Director of BH, and our AVP of LTSS. Molina Healthcare of Iowa follows a hierarchy of criteria, any changes to our criteria will be communicated to our providers 30 days prior to changes taking effect.		
HSAG Findings: Although the MCO demonstrated its PEGA system in the test environment, it had not yet been deployed to the production environment. **Recommendations:** After the site review, the MCO provided its IA State Training Addendum, which the MCO indicated is used to train staff members on Iowa-specific requirements. As specific guidance is received from HHS about contract expectations, the MCO should revise this training document as appropriate to ensure it remains complete and accurate. Additionally, the training document included a dental vendor. As dental benefits are covered primarily by an Iowa prepaid ambulatory health plan (PAHP), the MCO should determine if this delegate is appropriate for the Iowa plan and remove as appropriate.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Provide confirmation that its authorization system, PEGA, is live in the production environment.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa confirms that the authorization system (PEGA) will be deployed to the live production environment on the evening of June 19, 2023, and will be ready for demonstration, as requested by HHS and HSAG, on June 20, 2023.		
Individual(s) Responsible: Michael Wharton and Jeff Cangialosi		
Completion Date: 6/20/23		
HSAG Feedback: The MCO's remediation plan is sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Time Frames for Decisions		
40. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO mails the ABD notice to the member within at least ten (10) days before the date of action, except as permitted under 42 CFR §431.213 and §431.214. 42 CFR §431.211 42 CFR §438.404(c)(1) Contract H.3.01	**HSAG Required Evidence:** • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms • Staff training materials • HSAG also uses the results of the system demonstration **Evidence as Submitted by the MCO:** • IA HCS 325.01 Service Authorization Procedure II.k.e page 7 • IA 2023 HCS Program Description page 41 • UMMT TAT MONITORING Presentation Readiness - Entire document • IA Combined Roles and CRP Detailed Agenda - Entire document • IA CRC IP Role Specific NEO Agenda 12-5-23 - Entire document • IA CRC PA Role Specific NEO Agenda 12-5-23 - Entire document • IA MHIA Medicaid Denial_Draft Iowa Health Link.docx - Entire document • IA MHIA Medicaid Denial_Draft Iowa Hawk I.docx - Entire document	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: All member notifications are provided within the state regulatory timeframes. Member and provider letter are mailed at the time of decision, the provider is also faxed a copy of the decision at the time of the decision. Staff training are being developed using three Agendas and UM Program Descriptions and other UM materials.		
HSAG Findings: After the site review, the MCO provided an updated HCS-325.01 Service Authorization policy indicating the MCO will mail the ABD notice to the member within at least 10 days before the date of action. However, the notice template provided after the site review indicated, "The request from you or your doctor for more of the services below will be <denied> <reduced> <suspended> 10 days from the date of this letter." However, this language implies that the provider submitted a new request for services and that the MCO is not approving all requested services (e.g., partial denial). Termination, suspension, and/or reduction of services requirements apply to previously authorized services that are still in place but the MCO has determined are no longer appropriate or the number of services are no longer medically necessary. Additionally, the notice indicates that "this request for health care services has been reviewed to decide if it is a covered benefit and/or the service is medically necessary. This request has been denied. If you have not yet had these services and you go ahead and get these services, they will not be covered, and you will have to pay for them." This language implies that the services were not already in place.		
Required Actions: In order to receive a *Met* score for this element, the MCO must develop an advanced notice template for terminations, reductions, and suspensions that demonstrate understanding of the termination, reduction, and or suspension of previously authorized services.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa has uploaded our advanced notice templates to SAFE, "MHIA Suspend Term Reduce Hawk I 05.22.2023" and "MHIA Suspend Term Reduce Health Link 05.22.23," for terminations, reductions, and suspensions, which address HSAG feedback.		
Individual(s) Responsible: Jill Villalobos, Kim Nelson, and Christa Ross		
Completion Date: 5/31/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Practitioner Verification of Credentials		
17. *For credentialing and recredentialing, the MCO ensures that all required criminal history record checks and child and dependent adult abuse background checks are conducted for LTSS providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks. This includes but is not limited to non-agency affiliated self-direction service providers such as Consumer-Directed Attendant Care (CDAC) and Consumer Choices Option (CCO) employees.* a. *Each of the State's 1915(c) HCBS waivers and 1915(i) State Plan HCBS habilitation program, delineate the minimum provider qualifications for each covered service. The MCO ensures all HCBS providers meet these qualifications in accordance with Iowa Administrative Code Chapter 441-77.* Contract E.3.06	**HSAG Required Evidence:** • Policies and procedures • Required qualifications for CDAC and CCO providers • One example each of a completed credentialing file for a CDAC and CCO provider • Staff training materials • HSAG will also use the results of the Practitioner Credentialing File Review Tool, as applicable **Evidence as Submitted by the MCO:** • IA _Record Check Consent - Entire Document • IA _State Addendum Page 3 • IA _Assessment of Organizational Providers Addendum Page 1; Pages 3-4 • IA_CDAC Medicaid Enrollment - Entire Document • IA _Cred-Recred Training Plan (Tab IA Addendum)	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa is in the process of contracting with Veridian to complete certain functions in the onboarding of CCO Providers. Veridian requires employees to go through background screenings at the time of hire to include Criminal History Records, Sex Offender Registry, and Central Abuse Registry for Child and Dependent Adult Abuse. Employees are also required to go through Medicaid Exclusion checks at the time of hire and monthly thereafter. Molina Healthcare of Iowa requires individual CDAC providers to be enrolled in Medicaid. Part of the enrollment process requires individuals to complete a Record Check Consent (Form 470-4227). The Record Check Consent Form verifies Sexual Offender Registry, Child Abuse Registry, Dependent Adult Abuse Registry, and Criminal History Records. Molina Contracting verifies Medicaid Enrollment for individual CDAC providers using the Provider Master File (PMF).		
HSAG Findings: The MCO indicated that it is in the process of contracting with Veridian to complete certain functions in the onboarding of CCO providers such as background screenings at the time of hire to include criminal history record checks and child and dependent adult abuse background checks. However, HSAG was unable to verify the contract was executed. After the site review, the MCO indicated the business associate agreement language with Veridian is almost agreed upon and the MCO is awaiting final review from Veridian for it to be executed. The master's service agreement		

Operational Readiness Review Standards Remediation Plan		
Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
(MSA)/scope of work (SOW) are currently under negotiation. The current SOW states that Veridian will perform the criminal and background checks and is not in dispute, as each party has verbally agreed to that SOW; however, the executed version remains pending.		
Required Actions: In order to receive a *Met* score, the MCO must submit a signed executed contract with Veridian with criminal and background checks, and sanction and exclusion screenings included in the SOW. **Recommendations:** HSAG received clarification from HHS that HHS completes all required criminal history checks and child and dependent abuse background checks. MCO staff members also confirmed that the MCO will verify individual CDAC providers are enrolled with Iowa Medicaid. However, HSAG recommends that the MCO ensure staff training includes comprehensive information on CCO and CDAC. Additionally, HSAG recommends that the MCO clarify with HHS if ongoing background checks are required periodically and, if so, who is responsible for the ongoing background checks (e.g., HHS or the MCO).		
Plan to Remedy Deficiency: Molina Healthcare of Iowa will provide HSAG with a signed and executed contract with Veridian once completed. The contract is in the final stages and Molina is targeting contract execution no later than June 9, 2023, at which time Molina will provide a copy of the fully executed agreement and related SOW to HSAG. Relevant to this element, please note that the following language is included in the SOW with Veridian. This language has been negotiated and is not in dispute: c. Independent Contractor and Employee Screening. i. Screen each CCO employee and independent contractor against the Office of the Inspector General Exclusions List and the Iowa Medicaid Sanction List at time of enrollment and monthly thereafter. ii. Screen each CCO employee/independent contractor against the Single Contract Repository at the time of hire. (Iowa Criminal History, Sex Offender Registry, and Central Abuse Registry for Child and Dependent Adult Abuse). iii. Track the completion date for the background check for any newly enrolling CCO employee/independent contractor. iv. Coordinate with the employee/independent contractor any requests for additional information required by the HHS background check evaluator. v. Notify each Member when the background screening is complete. vi. Electronically store all forms and communication regarding the background check in accordance with state and federal privacy regulations.		
Individual(s) Responsible: Rich Russell and Anthony Carroll		
Completion Date: 6/9/23		

Operational Readiness Review Standards Remediation Plan		
Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Timely Resolution and Notification of Grievances		
7. The MCO resolves each grievance, and provides notice *in writing*, as expeditiously as the member's health condition requires, within HHS-established time frames that may not exceed the time frames specified in 42 CFR §438.408. a. The MCO resolves the grievance and sends notice to the affected parties *within thirty (30) calendar days* from the day the MCO receives the grievance. 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §438.228 Contract H.10.04 Contract H.10.07	**HSAG Required Evidence:** • Policies and procedures • Grievance resolution notice template • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Standard Grievance SOP pg. 2 • IA_Pega Reporting Training • IA_ Grievance Written Resolution Letter • IA_Grievance Procedure Addendum: pg 1 • IA_Medicaid Grievance Policy pg. 2	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa will send written resolution letters as quickly as the members health conditions requires and not to exceed 30 calendar days from the date the grievance is received. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Standard Grievance SOP.		
HSAG Findings: The grievance standard operating procedure (SOP) included a first call resolution process in which the case is closed if the grievance was resolved by the contact center and there is no need for follow-up. MCO staff members explained that first call resolutions will still be documented within its system, tracked, and reviewed by the grievance team. However, regardless of whether the member's grievance was resolved during the call with the contact center, the MCO must follow federal and state-specific grievance processing requirements and, therefore, must send a written resolution letter to the member. After the site review, the MCO provided the following narrative: "Molina does and will comply with all requirements, including written notification, on any Grievance - regardless of whether the Grievance was resolved during the initial call or contact from the affected party." However, the MCO did not update its grievance SOP to clearly outline this expectation. The grievance SOP implies that first call resolutions are closed and does not clearly specify that the grievance team would send a grievance resolution letter to the member. Please note, these findings apply to member grievances/expressions of dissatisfaction and not general inquiries received by the contact center.		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: In order to receive a *Met* score for this element, the MCO must update its grievance SOP to clarify that a grievance resolution letter will be sent for grievances resolved by the contact center (i.e., first call resolution).		
Plan to Remedy Deficiency: Molina Healthcare of Iowa has updated the "Staff Training IA _Standard Grievance SOP" to include clarifying language that a grievance resolution letter is sent for grievances taken by the Contact Center and resolved at the time of the call. The "Staff Training IA _Standard Grievance SOP" has been uploaded to SAFE.		
Individual(s) Responsible: Alex Matheason and Jeff Larsen		
Completion Date: 5/31/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Resolution and Notification of Appeals		
26. The MCO may extend the standard or expedited appeal resolution time frames by up to fourteen (14) calendar days if: a. The member requests the extension; or b. The MCO shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.408(c)(1) 42 CFR §438.228 Contract H.7.02 Contract H.7.05	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Staff training materials • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 6 • IA_Appeals Core Policy pg. 3 • IA_Appeals Core Procedure pg. 1	☐ Met ☒ Not Met
MCO Description of Process: The member may request a 14-day extension. If Molina Healthcare of Iowa requests the extension we will explain why it is in the member's best interest. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG received clarification from HHS that it requires the MCO to seek HHS approval to extend an appeal resolution time frame as the member has additional appeal rights with the State agency. After the site review, the MCO indicated its current appeals policy meets the requirements of this element. Policy language cited by the MCO is as follows: "Molina may extend the timeframe for processing an appeal and expedited appeal by up to fourteen (14) calendar days if the enrollee requests the extension, or if Molina shows that there is need for additional information and that the delay is in the enrollee's interest (upon state request)." However, this language does not clearly state that HHS approval is required for the MCO to extend the appeal resolution time frame.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Submit an updated appeal procedure that specifically indicates the MCO must seek HHS approval of an appeal resolution time frame prior to applying the extension. • Update its staff training and procedure document to include a time frame in which coordinators must seek HHS approval of the extension prior to the 30-day/72-hour due date and the mechanism in which coordinators are to seek approval from HHS (e.g., who at HHS to contact and how).		
Plan to Remedy Deficiency: Molina Healthcare of Iowa updated the Appeals Procedure State Addendum and the staff training standard operating procedure (SOP) to include the process of requesting approval for an extension from the State. The "MHI AG 01.01. IA Appeals State Fair Hearing IA State Addendum_Updated 05.22.23" and "Staff Training IA_Member Appeal SOP Updated 05.22.23" have been uploaded to SAFE.		
Individual(s) Responsible: Alex Matheason and Jeff Larsen		
Completion Date: 5/31/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
29. For all appeals, the MCO provides written notice of the appeal resolution that includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a State fair hearing, and how to do so.	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Staff training materials • HSAG will also use the results of the system demonstration	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may, consistent with *441 IAC 7.17(3)*, be held liable for the cost of those benefits if the hearing decision upholds the MCO's ABD related to the appeal. 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §438.10 42 CFR §438.228 Contract H.8.01	**Evidence as Submitted by the MCO:** • Staff Training IA_Member Appeal SOP pg. 8 • IA_post service denial resolution ltr • IA_pre-service denial resolution ltr • IA_Appeals Core Policy pg. 3 • IA_Appeals Core Procedure pg. 3-4 • IA_Appeals Addendum Iowa pg. 1	
MCO Description of Process: The appeal denial letter will state the reason for denial, date of denial, the right to request a state fair hearing and how to do so. The letter also advises how the member may request receiving benefits during the hearing and if the hearing upholds Molina Healthcare of Iowa's decision that the member may be responsible for the cost of the services received. Molina Healthcare of Iowa Staff training is under development and will include the Staff Training IA_Member Appeal SOP.		
HSAG Findings: HSAG received clarification from HHS that all addresses for members or providers to return or submit any mail must be located within Iowa. Please note, this finding applies to all member and provider written materials and not just the appeal resolution letter template. This finding aligns with the MCO's contract requirement with HHS to encourage a local presence in Iowa, particularly in relation to the delivery of member and provider services. After the site review, the MCO explained that HHS has requested a plan regarding out-of-state addresses that is due on April 27, 2023. The MCO is working to develop that plan and has already created a post office (PO) box for the receipt of mail related to appeals and grievances. This address has been shared with HHS in the MCO's updated member handbook. **Recommendations:** HSAG recommends that the MCO seek clarification from HHS as to whether HHS expects the reference to 441 IAC 7.17(3) to be included in the member appeal resolution letter template.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Provide an Iowa-based mailing address for members and providers. • Provide confirmation that all member and provider written materials have been updated with the Iowa-based mailing address.		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
• Develop a process to physically obtain mail from the PO box and distribute to the appropriate department timely (HSAG is concerned a possible delay may occur in collecting and subsequently distributing materials to the appropriate department if the MCO does not have a process to regularly collect mail throughout each business day from the PO box versus having mail delivered to a mail room at the MCO's office). • Provide confirmation that HHS has approved the MCO's plan for receiving mail at the MCO's Iowa-based mailing address.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa has an Iowa address for Members and Providers. All written member and provider materials, including the provider manual and member handbook located on the public website, have been updated with the Iowa address for the Appeals and Grievances team, which is: Appeals & Grievances Molina Healthcare of Iowa PO Box 93010 Des Moines, IA 50393 Molina has also developed processes related to the delivery of mail to our Iowa office location, the physical retrieval, and the processing of all mail. The process includes expected turnaround times to distribute any necessary information to appropriate business areas to mitigate delays in downstream processes. We have uploaded the "Staff Training IA Mail Handling SOP" to SAFE. Molina has uploaded to SAFE the "HHS Approval Email 4-28-23 for 23-MO-318 Molina Mailing Address Plan" email for Molina's Iowa-based mailing address plan.		
Individual(s) Responsible: Alex Matheason and Jeff Larsen		
Completion Date: 5/31/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area. However, HSAG recommends that the MCO immediately date/time stamp receipt of member grievances and appeals when received through the mail process. This is particularly important for expedited cases as the time frame must begin upon the receipt date/time, and the MCO has 72 hours for resolution.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Monitoring and Auditing		
8. *Prior to delegation, the MCO evaluates the prospective subcontractor's ability to perform the activities to be delegated, including firm and staff qualifications.* 42 CFR §438.230 Contract J.3.03	**HSAG Required Evidence:** • Policies and procedures • Pre-delegation audit tool template • Staff training materials • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • IA_4_IA_ Delegated Services Adden_TMP1, Section 1.3, page 2 of 26 • IA_Delegation Oversight Program Policy, Section II, B.1., page 2 of 7 • IA_Delegation Oversight_Proced, Section II.I.A-C page 2 of 6 • IA_2022 Pre-Del Cred Audit - CHI Health Notice, Entire document • IA_CHI_2023 Preassessment Audit Summary, Entire document • IA_Cred Audit Tool_Example, Entire tool • IA_GC-01 Subcontractors Policy, Section II.E, page 1 of 3 • IA_IA Contract Req Staff Training – DO, Entire document • IA_Pharm_Ops_Surveillance_Procedure, Section V.D. page 2. • IA_2023 Pre-Delegation Audit_CVS_Caremark Notice, Entire document.	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• IA_Pharm_Ops_Surveillance_PBM Plan, Section: Cycle 1, page 3 & Table 2 page 5-6. • IA_Pharmacy Training. Slides 13-19	
MCO Description of Process: Molina Healthcare of Iowa conducts pre-delegation audits/reviews for all prospective delegates testing and validating that they can perform the activities they are delegated to perform.		
HSAG Findings: The IA_4_IA_ Delegated Services Adden_TMP1 policy addendum identified that prior to delegating functions, the MCO would conduct a comprehensive pre-delegation assessment of the provider's ability and administrative capabilities to perform each delegated function. One of the three delegate files reviewed did not include the pre-delegation assessment. In follow-up to the site review, MCO staff members indicated that the MCO was still in the process of completing the pre-delegation assessment.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Provide the completed pre-delegation assessment for CVS Caremark. • Provide written confirmation when the MCO has completed all Iowa Medicaid managed care subcontractors' pre-delegation assessments.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa has completed the pre-delegation assessment for CVS Caremark and has uploaded the "2023 CVS IA Pre-Del Audit Summary" document to SAFE. Molina confirms that by June 28, 2023, we will have completed all Iowa Medicaid managed care subcontractors' pre-delegation assessments. Molina's next delegate report, due June 9, 2023 to HSAG, will provide a status report of all completed pre-delegation assessments as of that date.		
Individual(s) Responsible: Michelle Riegler and Anthony Carroll		
Completion Date: CVS Caremark pre-delegation assessment - 5/24/23; Confirmation of subcontractors' pre-delegation assessments – 6/28/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Organizational Structure and Staffing		
37. *The MCO provides an initial operational staffing plan to HHS following the requirements in Section A of the Contract. In its staffing plan, the MCO:* a. *Ensures that staff delivering care coordination and community-based case management services are based in Iowa at locations that will facilitate the delivery of in-person services as appropriate;* b. *Includes no less than the staffing areas listed in the Staffing Checklist;* c. *Encourages a local presence in Iowa, particularly in relation to the delivery of member and provider services;* d. *Includes a backup personnel plan, including a discussion of the staffing contingency plan for:* i. *The process for replacement of personnel in the event of a loss of key personnel or others before or after signing the Contract;* ii. *Allocation of additional resources to the Contract in the event of an inability to meet a performance standard;* iii. *Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience;* iv. *The time frame necessary for obtaining replacements;* v. *The method of bringing replacements or additions up to date regarding the Contract;* e. *Includes a resume for each key personnel member; and*	**HSAG Required Evidence:** • Policies and procedures • Job descriptions for all personnel defined in the Staffing Checklist • Operational Staffing Plan (as requested via the Questionnaire) • HSAG will also use the results of the Staffing Checklist **Evidence as Submitted by the MCO:** • Iowa HSAG- Staffing Checklist-JD's • IA_GC-04 Molina Iowa Staffing Policy, pages 1-2 • IA _RRQ _ Attachment 7_Org Chart _Operational Areas • IA _ Key Personnel Table • MOL_IA2023_RR_Std XIV _ Staffing Checklist	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
f. *Describes what functions are proposed to be conducted outside of Iowa and how out-of-State staff will be supervised to ensure compliance with Contract requirements.* Contract A.04-A.07		
MCO Description of Process: Molina Healthcare of Iowa's initial operating staffing plan meets the requirements as set forth in the contract.		
HSAG Findings: While the MCO maintained a staffing plan, there remains a significant number of staff vacancies (e.g., grievance and appeal staff, member and provider services, credentialing, utilization management). HSAG recognizes that the hiring of staff is an ongoing process; therefore, HSAG expects that the MCO will be able to demonstrate progression in the hiring of staff through the submission of ongoing reports.		
Required Actions: In order to receive a *Met* score for this element, the MCO must demonstrate that it has made significant progress in filling the open staff positions.		
Plan to Remedy Deficiency: Our May 26, 2023 staffing plan submission, "Molina Staff Resources Monitoring State Workbook 5-26-23 report", which has been re-uploaded to SAFE, demonstrated significant progress in closing open staffing positions and reconciling to an appropriate staffing level to support our adjusted membership allocation. More specifically, that report showed 95% of updated planned positions have been filled. Molina Healthcare of Iowa will continue to submit updated staffing plan reports on a bi-weekly basis to both HSAG and HHS that demonstrate progress toward filling open staff positions. Molina will continue to follow HHS's ongoing guidance of expectations for formatting and content.		
Individual(s) Responsible: Anthony Carroll, Theresa Jennings, and Allison Sandoval		
Completion Date: 6/23/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
38. The MCO provides initial and ongoing training and ensures all staff are trained in the areas listed in the Staff Training Checklist. a. *The MCO maintains documentation to confirm staff training, curriculum, schedules, and attendance.* Contract A.13	**HSAG Required Evidence:** • Policies and procedures • Staff training tracking mechanisms • Staff Training Plan (as requested via the Questionnaire) • HSAG will also use the results of the Staff Training Checklist **Evidence as Submitted by the MCO:** • IA_GC-04 Molina Iowa Staffing Policy, page 2 Molina Staff Training Responsibilities • IA_C-01.3 Effective Training and Education. Entire Document • IA _RRQ _Attachment 9_Training Plan • MOL_IA2023_RR_StdXIV_Staffing Training Checklist_T1 IA _iLearn- screenshot	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare of Iowa provides initial and ongoing training and ensures all staff are trained in the areas listed in the Staff Training Checklist.		
HSAG Findings: While the MCO demonstrated that it has the processes in place to train staff initially and annually, the Molina Staff Resources Monitoring documents submitted after the site review did not support that the MCO has fully trained staff members in most program areas. HSAG recognizes that the hiring of staff and subsequent training of staff is an ongoing process; therefore, HSAG expects that the MCO will be able to demonstrate progression in the training of staff through the submission of ongoing reports.		
Required Actions: In order to receive a *Met* score for this element, the MCO must: • Demonstrate that it has made significant progress in fully training staff members.		
Plan to Remedy Deficiency: Our May 26, 2023 staffing report submission, "Molina Staff Resources Monitoring State Workbook 5-26-23 report", which has been re-uploaded to SAFE, demonstrated significant progress, particularly in the completion of training by Molina's Case Management team and other		

Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Clinical staff. Molina Healthcare of Iowa will continue to submit updated staff training reports on a bi-weekly basis to both HSAG and HHS that demonstrate progress towards the completion of fully training staff members.		
Individual(s) Responsible: Anthony Carroll, Theresa Jennings, and Matt Gunnon		
Completion Date: 6/23/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Appendix C. Information Systems Readiness Review Standards

Standard I—Enrollment Systems		
Requirement 1: Health Information System and Required Functions—The MCO shall maintain an Enrolled Member database, using Medicaid State ID numbers, on a county-by-county basis which contains eligibility begin and end dates, enrollment history, county of legal residency, and information on disenrollment reasons other than loss of Medicaid eligibility. *The MCO should describe in detail its systems for managing enrollment and the dissemination of enrollment information to downstream systems (e.g., claims processing, pharmacy, and care management). Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.*		
Reference—*42 CFR 438.242(a), HHS Contract Sections K.03. and K.12.*		
Score:	☒ Met	☐ Not Met—Action Required
Findings:	HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.	
Required Action:	None.	

Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
MEG_PROCESS_FLOW_DIAGRAM IA _Enrollment and Disenrollment PnP IA _Molina Overall Systems v4 IA_ISCAT_AdminData_20 IA _Enrollment and Eligibility	*Molina Eligibility Gateway (MEG) is internal system built on Microsoft BizTalk and .Net technologies that serves as our streamlined eligibility, enrollment, and disenrollment management and data exchange platform.* *MEG is automated end-to-end eligibility inbound processes, decreasing processing time and improving overall performance.* *Molina's enrollment process begins upon receipt of daily or monthly enrollment files from HHS. Our Eligibility Validation Engine processes the file through initial validation procedures that confirm file layout, record counts, and HIPAA compliance. Once validated, the information is processed within 24 hours and then stored in QNXT. The file is reconciled against internal Member information and, if a difference is found, the Member record is updated appropriately to match HHS information. Once the record is updated, a new ID card is issued to the Member if any critical information has changed that affects the card (for example: name, benefit plan).*

Standard I—Enrollment Systems		
Requirement 2: Interface with State Systems and Member Enrollment Data—The MCO's information systems shall have the capacity to electronically receive HIPAA-compliant 834 enrollment files through a file transfer process with the Agency's Title XIX eligibility system in a manner, time frame, and frequency determined by HHS. a. Extraction, transformation, and load (ETL) processes used by the MCO must be documented in detail and approved by HHS. b. The MCO must report inability to retrieve or load eligibility data for any reason to the sending trading partner and the Agency on the same business day as transmission. c. The MCO must not modify Enrolled Member identifiers, eligibility categories, or other Enrolled Member data elements without written approval from the Agency. *The MCO should describe, in detail, how it processes enrollment, disenrollment, and changes to the recipient's enrollment information in the MCO's systems from the daily and monthly enrollment files provided by HHS. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.*		
Reference—HHS Contract Sections K.26. and K.39(a)		
Score:	☐ Met	☒ Not Met—Action Required
Findings:	The MCO submitted policies and procedures that described the process of loading enrollment data into its system and indicated during the site review that member services staff only have the ability to update a member's address for 90 days. The MCO indicated that enrollment staff have the ability to edit member data in QNXT to ensure that the data match the 834 file as the source of truth, and it has multiple audit reports to ensure that data loaded in QNXT match the raw 834 files received from HHS. The IA_EnrollmentandEligibility policy included language that meets Requirement 2a and 2b. However, the MCO did not provide evidence that its ETL processes were documented in detail and approved by HHS as stated in Requirement 2a.	
Required Action:	In order to receive a *Met* score, the MCO must: • Provide evidence that Molina submitted detailed documentation of its ETL processes for HHS approval. • Provide the testing plan and status of testing with HHS for the exchange of 834 enrollment files.	

Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
MEG_PROCESS_FLOW_DIAGRAM IA _Enrollment and Disenrollment PnP IA _Molina Overall Systems v4 IA_In834NotInQNXT_Report IA_InQNXTNoton834_Report	*HIPAA 834 monthly enrollment files are full replacement files and show current status for each Member. Our process reads each record and validates the information currently in our system. If a change is found, the system is updated with the new information. Daily eligibility files contain new, changed, and terminated Members, whose information we load into QNXT before the*

Standard I—Enrollment Systems	
IA _Enrollment and Eligibility	*next business day. As part of our standard process, we reconcile the data on each file with what is loaded in our eligibility and enrollment system, check for duplication, and discrepancies are sent to Molina Member Workflow (MMW) for our Enrollment team's review.* *If exceptions are generated during any part of the enrollment data load, including 834 file load, PCP assignment, and vendor extracts, an exception is generated. The exception is then made available to the Enrollment team and in our Member Workflow to resolve the conflict and process the record.*

Standard I—Enrollment Systems		
Requirement 3: Member Enrollment Data—The MCO shall reconcile its eligibility and capitation records for each member monthly. a. If the MCO discovers a discrepancy in eligibility or capitation, the MCO shall provide notification in a manner specified by the Agency. b. The MCO shall return any capitation or Overpayments to the Agency within sixty (60) Days of discovering the discrepancy via procedures determined by the Agency. c. If the MCO receives either enrollment information or capitation for an Enrolled Member, the MCO is financially responsible for the Enrolled Member unless the MCO has not received capitation for that Enrolled Member ninety (90) Days following notification to the Agency that a capitation was not received. *The MCO should describe, in detail, monthly enrollment reconciliation processes. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.*		
Reference—*HHS Contract Section K.39(b)*		
Score:	☒ Met	☐ Not Met—Action Required
Findings:	HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.	
Required Action:	None.	

Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
IA_MHI - Policy and Procedure for Premium 820 Reconciliation IA_PRA Overview IA _Discrepancy Resolution between QNXT and Payment	*Molina uses the Premium Reconciliation Application to reconcile enrollment and payment from 820. The application interfaces with the enrollment system and compares each eligible member month to the paid capitation from the 820. Discrepancies are created to identify 1) covered members not yet paid 2) paid membership missing eligibility 3) overpaid/underpaid discrepancies when the expected premium does not match paid premium from 820. Discrepancies are routed for enrollment review. If the discrepancy can be resolved by making an update to member eligibility, the item is closed. The discrepancy is otherwise routed to the state for member eligibility or payment review.*

Standard I—Enrollment Systems		
Requirement 4: Use of a Common Identifier—The MCO may use a common identifier, including Enrolled Members' Social Security numbers, to link databases and computer systems as required in the Contract. However, the MCO shall not publish, distribute, or otherwise make available the Social Security numbers of Enrolled Members. *The MCO should provide its policies, procedures, and a description of its systems for managing this requirement. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.*		
Reference—HHS Contract Section K.27.		
Score:	☒ Met	☐ Not Met—Action Required
Findings:	HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.	
Required Action:	None.	

Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
IA _Information Protection Standard_ITS-008 (1) pg. 6-7 IA_MHI HP 20 - Creating De-identified Information pg.2-3 IA_MHI HP 03 - Privacy and Confidentiality of PHI pgs. (1-2, 7-8, 10-11)	*Social Security Numbers are not used as the primary common identifier within any Molina database, and SSN is masked within the system.*

Standard I—Enrollment Systems		
Requirement 5: Managed Care Excluded Populations—The populations in this section are excluded from enrollment in the Medicaid managed care program. a. Non-qualified aliens receiving time-limited coverage of certain Emergency Medical Conditions. b. Beneficiaries who have a Medicaid eligibility period that is retroactive. c. Persons eligible for the PACE who voluntarily elect PACE coverage. d. Persons enrolled in HIPP. e. Persons deemed Medically Needy. f. Persons incarcerated and ineligible for full Medicaid Benefits. g. Persons presumed eligible for services (i.e., Presumptive Eligibility). h. Persons residing in the Iowa Veteran's Home. i. Effective July 1, 2017, beneficiaries who are eligible only for the Family Planning Waiver. j. Persons eligible only for the Medicare Savings Program. k. Alaskan Native and American Indian populations shall be enrolled voluntarily. *The MCO should describe its processes for ensuring that enrollment data received and processed into its enrollment data system is for populations eligible for the managed care program only and should describe its process for communicating any issues with or discrepancies in enrollment data to HHS. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.*		
Reference—HHS Contract Exhibit D		
Score:	☐ Met	☒ Not Met—Action Required
Findings:	The MCO submitted a policy that indicates these populations are excluded from managed care and indicated during the site review that they would not be loaded into QNXT due to rate codes that would not pass the MCO's validation process; however, the policy indicated that HHS was responsible for ensuring that these consumers are not included on the 834 files rather than describing how the MCO would handle a situation in which one of these consumers was included on an 834 file.	
Required Action:	In order to receive a *Met* score, the MCO must provide the updated IA_Included and Excluded Populations policy that describes the steps the MCO would take or system controls used to ensure that these consumers would not be loaded into the MCO's systems during the 834 loading process and how the MCO would notify HHS of the consumers being included on the file.	

Standard I—Enrollment Systems	
Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
IA _Included and Excluded Populations pgs. 3-4	*Members that are included in the excluded populations are not sent on the 834 extract and therefore are not enrolled into the MCO. The MCO enrolls members that have met the States requirements and are sent on the daily and monthly extract. If at any time during enrollment, the MCO learns of member being part of the managed care excluded population, departments will route disenrollment request through the Enrollment and Government Contracts teams to the State agency.*

Results for Standard I—Enrollment Systems			
Total Elements	**5**	**Required Action: Process-related Elements**	• The MCO must provide the updated IA_Included and Excluded Populations policy that describes the steps the MCO would take or system controls used to ensure that these consumers would not be loaded into the MCO's systems during the 834 loading process and how the MCO would notify HHS of the consumers being included on the file.
Met	**3**		
Not Met	**2**	**Required Action: System-related Elements**	• The MCO must provide the testing plan and status of testing with HHS for the exchange of 834 enrollment files. • The MCO must provide evidence that the MCO submitted detailed documentation of its ETL processes for HHS approval.

Standard II—Claims and Encounter Systems		
Requirement 1: Claims Processing and Encounter Systems—The MCO must have a claims processing system and Management Information System (MIS) that: a. Collects data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission) in accordance with section 6504(a) of the Affordable Care Act. The MCO must provide electronic remittance advice and transfer claims payment electronically. The MCO must have the capacity to process paper claims and track electronic versus paper claim submissions over time to measure success in increasing electronic submissions. The MCO must be able to maintain data on incurred but not yet reimbursed claims and data on the time required to process and mail claims payment. The MCO must be able to submit daily files of pre-adjudicated claims (i.e., shadow claims) that were received on the previous day to HHS in 837I and 837P formats. b. Enables the MCO to manage and monitor its system to ensure collection of encounter data received from providers is accurate and timely; screen the data for completeness, logic, and consistency; and collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in accordance with 42 CFR 438.242(b) and (c). Include a description of the process utilized when a capitated provider fails to submit encounters or submits encounters without paid claims. c. Collects and maintains data on member and provider characteristics as specified by HHS, and on services furnished to the recipients through an encounter data system or other method as may be specified by HHS. The MCO must be able to generate information specific to service type, including but not limited to: (i) Behavioral Health Services; (ii) LTSS; (iii) pharmacy; (iv) inpatient services; and (v) outpatient services. The MCO makes all collected data available to HHS and upon request to CMS. d. Accommodates billing of LTSS recipients a predetermined Client Participation amount for the cost of LTSS services and process claims in accordance with the participation amount and pay providers the net of the applicable Client Participation amount. The MCO must implement a mechanism to establish which provider the enrolled member is to pay their Client Participation on a monthly basis. e. Accommodates billing of specified enrolled members a cost sharing amount and reduce the payment it makes to a provider by the amount of the member's cost sharing obligation. The MCO must implement a mechanism to notify providers of an enrolled member's financial participation or cost sharing requirement. *The MCO should provide a description of its systems for managing the claims processing and encounter data requirements. Evidence includes process flows, policies and procedures, system manuals, process manuals, etc.*		
Reference—42 CFR 438.242; HHS Contract Sections K.04, K.05, K.06, K.07, K.09, K.10(a), K.12(g)(h)(o) and K.41		
Score:	☐ Met	☒ Not Met—Action Required
Findings:	The policies and procedures submitted for this requirement indicate that the MCO's processes for claims adjudication, validation procedures for ensuring claims and encounter files meet requirements, and that auditing/monitoring process to ensure accuracy meet this requirement. The MCO demonstrated during the site review that it has sufficient processes in place to monitor timeliness of claims adjudication. The	

Standard II—Claims and Encounter Systems	
	MCO also demonstrated in its test environment that the claims system is fully configured to adjudicate all claims using Iowa billing requirements. However, the system has not yet been deployed to the production environment for the Iowa Medicaid managed care program.
Required Action:	In order to receive a *Met* score for this element, the MCO must: • Provide confirmation that its claims payment system is live during the June 2023 system demonstration.

Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
1a. IA _MHC _Molina Healthcare Health Information Application Strategy Plan 2023 Page 1 to 7 and Page 11 to 14. 1b. Claim and Encounter Submission Methods- All States and LOBs-SOP 1b. Encounters Report Monitoring- All States and LOBs- SOP 1c. Claims Encounters Management System for Encounter Data Compliance 1c. IA SOP Reporting Approach Strategy and Delivery 1d. IA CP Workflow 1d. IA Claim- 110 MLTSS ClientPartPolicy-23 1e. IA Copayment Policy	*Molina Healthcare of Iowa, Inc. (Molina) is compliant with 42 CFR 438.242 and the Iowa Health Link contract. Molina and Iowa Health and Human Services (HHS) are meeting on 2/22/2023 to discuss the shadow claims process.*

Standard II—Claims and Encounter Systems		
Requirement 2: Claims Submission and Payment Requirements—The MCO must: a. Allow in-state network providers to submit claims for reimbursement up to 180 days from the last date of service, and allow out of state providers 365 days from the last date of service without requiring a MCO-specified provider number in order to receive payment. b. Pay 95 percent of all clean claims from providers within 30 calendar days of the date of receipt and pay 99 percent of all clean claims from providers within 90 calendar days of the date of receipt. c. Develop, implement, and adhere to policies and procedures, subject to Agency review and approval, to monitor claims adjudication accuracy. d. Develop, implement, and adhere to written policies and procedures for registering and responding to claim disputes, including a process for Out-of-Network Providers. e. Comply with the requirements related to claims forms as set forth in Iowa Admin. Code r. 441-80.2. Any claims forms or payment methodology developed by the MCO for use by providers shall be approved by the Agency and shall be in such a format as to assure the submission of encounter data as required under the contract. f. Require each physician providing services to enrolled members to have a standard unique health identifier in compliance with 42 U.S.C. § 1396u-2(d)(4). g. Require that all providers that submit claims to the MCO have a national Provider identifier (NPI) number unless otherwise directed to the Agency in accordance with 45 C.F.R. § 162.410. h. Collaborate with other Iowa Medicaid plans to provide consistent practices, such as on-line billing, for claims submission to simplify claims submission and ease administrative burdens for providers in working with multiple MCOs, including a strategy to handle Medicare crossover claims to help reduce the administrative burden on the providers. *The MCO should provide its policies and procedures for managing the claims processing and payment requirements. Evidence includes process flows, policies and procedures, sample reports, etc.*		
***Reference—**42 CFR 447.45, 45 CFR 162.410, 42 USC 1396u-2(d)(4), Iowa Admin. Code r. 441-80.2, HHS Contract Section K.41*		
Score:	☒ Met	☐ Not Met—Action Required
Findings:	HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.	
Required Action:	None.	

Standard II—Claims and Encounter Systems	
Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
a. IA Provider Manual 200923 – Page 106, Section 12 – Claim Timely Filing a. MHI.CLMS.02.01 Claims Timely Filing Procedure – entire document and page 5 specifically for Iowa b. MHI.CLM.05.02 Claims Payment Process Procedure – entire document and page 4 specifically for Iowa c. Claims Audit Unit Overview- All States and LOBs- SOP c. Claims Recovery SOP All States d. Erred Claims Tracker Audit Rebuttal Process- All States- All Lobs- Job Aide d. Policy-PI-REC-001-TPL Recoveries and Reporting of Overpayments d. IA Provider Manual 200923 – Page 119 e. IA Provider Manual 200923 – Page 121 f. IA Provider Manual 200923 – Page 99 g. IA Provider Manual 200923 – Page 107 h. IA Provider Manual 200923 – Pages 10, 110, 113 h. IA MHC Molina Healthcare Health Information Application Strategy Plan 2023 – page 13	*Molina Healthcare of Iowa, Inc. (Molina) is compliant with 42 CFR 447.45, 45 CFR 162.410, 42 USC 1396u-2(d)(4), IAC441-80.2, and the Iowa Health Link contract.*

Standard II—Claims and Encounter Systems		
Requirement 3: Encounter Data—The MCO must have the capacity to submit encounter data to the Agency's MMIS in accordance with the HHS contract including, but not limited to, the following: a. Submit encounter data, including prescribed data fields, to HHS by the twentieth (20th) of the following month (i.e., subsequent to the month for which data are reflected) in the standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. Drug encounter data is submitted by the MCO once every two (2) weeks for adjudicated claims in support of the Iowa Medicaid's Drug Rebate invoicing process identified in Section F.11 of the Contract. The MCO shall obtain Agency approval of policies and procedures, to support encounter claim reporting and shall strictly adhere to the Agency-approved policies and procedures as well as standards defined by the Agency for items such as the file structure and content definitions. b. Submit an encounter claim to HHS, or its designee, for every service rendered to a member for which the MCO either paid or denied reimbursement. The MCO must ensure these claims contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts, reimbursed amounts, and providers' identification numbers. The MCO must ensure that all encounter data reflects the amount actually paid to the Provider, including but not limited to the amount paid by any PBM or other Subcontractor. Regardless of participating provider status, the MCO must be able to reimburse Indian Health Care Providers the applicable encounter rates published annually in the Federal Register by the Indian Health Service (IHS), the FQHC rate the providers would receive in Fee-For-Service if enrolled in Medicaid as an FQHC, or the amount they would receive if the services were provided under the State Plan's FFS payment methodology. c. Submit all encounters with the National Provider Identifier (NPI) or an Atypical Provider Identifier (API) for providers that are neither a covered nor an eligible entity. d. Implement policies and procedures to ensure that encounter claims submissions are accurate. The MCO must submit timely and accurate reports in the format and time frame designated by HHS, with an error rate for encounter data that shall not exceed one percent (1%). The MCO must investigate root cause of report inaccuracies and submit a revised report in the time frame designated by HHS. All corrections to the monthly encounter data submission must be finalized within forty-five (45) days from the date the initial error report for the month was sent to the MCO or fifty-nine (59) days from the date the initial encounter data were due. e. Implement a system for monitoring and reporting the completeness of claims and encounter data received from providers. The MCO has in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided. The MCO demonstrates its internal standards for measuring completeness, the results of any completeness studies, and any corrective action plans developed to address areas of non-compliance. *The MCO should describe, in detail, its policies and procedures for preparing and submitting encounter data files. Evidence includes process flows, policies and procedures, system manuals, sample reports, etc.*		
Reference—*42 CFR 438.818, 42 CFR 438.14(c)(1), 42 CFR 457.1209, HHS Contract Section K.10(b-d), K.11, K.26, K.42, K.43, K.44 and K.45*		
Score:	☒ Met	☐ Not Met—Action Required

Standard II—Claims and Encounter Systems	
Findings:	HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.
Required Action:	None.

Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
Claim and Encounter Submission methods-All States and LOBs-SOP Encounters Report Monitoring- All States and LOBs- SOP	*Molina Healthcare of Iowa, Inc. (Molina) is compliant with 42 CFR 438.818, 42 CFR 438.14(c)(1), 42 CFR 457.1209 and the Iowa Health Link contract.*

Standard II—Claims and Encounter Systems		
Requirement 4: Information System Plan—The MCO must have policies and procedures for receiving, creating, accessing, storing, and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy, and security requirements (45 C.F.R. Parts 160, 162 and 164 and the HIPAA Security Rule at 45 C.F.R. § 164.308). The plan shall identify the steps to be taken and include a timeline with target dates. The plan shall include, but may not be limited to, a detailed explanation of the following: a. Planning, developing, testing, and implementing new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets; b. Concurrent use of multiple versions of electronic transaction standards and codes sets; c. Registration and certification of new and existing trading partners; d. Creation, maintenance, and distribution of transaction companion guides for trading partners; e. Staffing plan for electronic data interchange (EDI) help desk to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates; f. Compliance with all aspects of HIPAA Privacy and Security rules; g. Strategies for maintaining up-to-date knowledge of HIPAA-related mandates with defined or expected future compliance deadlines. *The MCO should describe, in detail, its plan for maintaining compliance with HIPAA standards for claims transactions. Evidence includes process flows, policies and procedures, system manuals, sample reports, etc.*		
Reference—*42 CFR 438.818, HHS Contract Section K.10.(b-d), K.11, K.43., K.44. and K.45.*		
Score:	☒ Met	☐ Not Met—Action Required
Findings:	HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.	
Required Action:	None.	

Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
MHIA INFORMATION SYSTEM PLAN Standard II Req4 – contains information and linked files for all items in requirement 4. Evidence page reference are listed in this document.	*Molina Healthcare of Iowa, Inc. has included document MHIA Information System Plan to describe our processes in compliance with 42 CFR 438.818 and the Iowa Health Link contract.*

Results for Standard II—Claims and Encounter Systems			
Total Elements	**4**	**Required Action: Process-related Elements**	• None.
Met	**3**		
Not Met	**1**	**Required Action: System-related Elements**	• The MCO must confirm its claims payment system is live during the June 2023 system demonstration.

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Systems Requirements		
1. The MCO maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to: a. Utilization b. Claims c. Grievances and appeals d. Disenrollments for other than loss of Medicaid eligibility 42 CFR §438.242(a) Contract K.02 Contract K.03	**HSAG Required Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Completed Information Systems Capabilities Assessment Tool (ISCAT) • Technical manual(s) • List of disenrollment codes (i.e., reasons for disenrollment) provided by HHS • Screenshot of disenrollment codes available in the disenrollment system • HSAG will use the results from the information systems demonstration, including reporting capabilities • HSAG will use the results from the systems demonstrations included as part of the Disenrollment Requirements and Limitations Standard, Coverage and Authorization of Services Standard, and the Grievance and Appeal Systems Standard **Evidence as Submitted by the MCO:** IA_MHC_Molina Healthcare Health Information Application Strategy Plan 2023 Page 1 to 7; System integration mapping is located on page 2 of the strategy plan. IA_MHC_Information Technology Policy_IS-01 Whole Document Technical Manuals: Element 1a: IA HCS-325.01 Service Authorization Procedure_IA RR Whole Document Element 1b: Claims Processing Overview - All States and LOBs – SOP Whole Document	☐ Met ☒ Not Met

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	Element 1c: IA _Standard Grievance SOP and IA_Appeals Core Procedure Whole Document Element 1d: IA_Enrollment and Disenrollment PnP Whole Document Molina Healthcare will use state 834 as the source of truth for member eligibility. HHS does not supply disenrollment code on the state 834, therefore Molina Healthcare cannot provide list of disenrollment code and screen shot.	
MCO Description of Process: Molina Healthcare of Iowa, Inc.'s ("Molina Healthcare of Iowa") fully integrated Management Information System (MIS) is built as the health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. It supports all Molina Healthcare operation and HHS health plan health information system requirements including claims, UM, appeals & grievances, and disenrollments.		
HSAG Findings: The MCO provided policies and procedures related to service authorization (utilization), claims processing, grievances and appeals management, and member enrollment and disenrollment. The Molina Healthcare Health Information Application Strategy Plan 2023 document included a table that lists the health information systems and applications the MCO uses to manage healthcare utilization (service review, prior authorization), claims, grievances and appeals, member eligibility (enrollment and disenrollment), and reporting requirements. Additionally, the document included workflow diagrams of processes and systems along with additional diagrams provided. However, it was unclear from the IA_Medicaid Information Systems diagram the function of all systems represented on the diagram and the timing of automated data feeds between systems. It was also unclear whether there were any manual workarounds planned for automated data feeds that will not be operational during the first phase of the Iowa plan implementation. Of note, MCO staff members stated that HHS does not supply the reason for a member's disenrollment on the 834 file. As HHS confirmed this is accurate, this finding was not considered a deficiency.		
Required Actions: In order to receive a *Met* score, the MCO must provide either an updated diagram or description of each system's function, whether data feeds are automatic as well as the timing, and when there are manual workarounds instead of data feeds from one system to another.		
2. *The IS implemented by the MCO shall include the following general system requirements but may not necessarily be limited to these requirements: (i) online access; (ii) online access to all major files and data elements within the IS; (iii) timely processing; (iv) daily file updates of Enrolled Member, Provider,*	**HSAG Required Evidence:** • Policies, procedures, and workflows • Completed Information Systems Capabilities Assessment Tool (ISCAT) • IS contingency plans	☐ Met ☒ Not Met

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Prior Authorization and Claims to be processed; and (v) weekly file updates of reference files and Claim payments. a. *Edits, Audits and Error Tracking: The MCO shall employ comprehensive automated edits and audits to ensure that data are valid and that Contract requirements are met. The IS shall track errors by type and frequency and maintain adequate audit trails to allow for the reconstruction of processing events.* b. *System Controls and Balancing: The IS shall have an adequate system of controls and balancing to ensure that all data input can be accounted for and that all outputs can be validated.* c. *Back-Up of Processing and Transaction Files: The MCO shall employ the following back-up timelines: (i) twenty-four (24) hour back-up of eligibility verification, enrollment/eligibility update process, and Prior Authorization processing; (ii) seventy-two (72) hour back-up of Claims processing; and (iii) two (2) week back-up of all other processes.* Contract K.13	• HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** Element 2.a and 2b: IA_MHC_ Information and Cybersecurity Policy_CS-01 Page 10 IA_MHC_Security Logging and Monitoring Standard_ITS-015.pdf whole document Element 2.c: IA_MHC_Information Technology Policy_IS-01.pdf Page 6 IA_MHC_MHI IT Disaster Recovery Plan - 2022 v4_8b.pdf whole document Element 2.a, 2.b and 2.c: IA_MHC_QNXT_Risk_Assessment_2022-12-19.xlsx whole document	
MCO Description of Process: In Molina Healthcare of Iowa's MIS, all edits and errors are logged and monitored. We have implemented a series of best industrial class system controls and balancing measures. In addition, all the data and changes are backed up per schedule based on the criticality of the information. To further demonstrate full compliance with these standards, our core administrative system QNXT system risk assessment is attached.		
HSAG Findings: While the MCO provided evidence to support it has sufficient processes to meet the requirements of this element, the MCO has yet to receive member historical files from HHS for its membership.		
Required Actions: In order to receive a *Met* score, the MCO must provide confirmation when data from other MCOs and from HHS (e.g., enrollment, prior authorizations, and historical claims) are loaded in the MCO's systems.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
3. *The MCO shall perform the following IS functions through a system that integrates the MCO's clinical record information, authorization and claims payment data:* a. *Reporting. Maintain information and generate reports required by the performance indicators established to assess the Contractor's performance.* b. *Capitation Payment. Maintain data documenting receipt and distribution of the Capitation Payment.* c. *Clinical Data. Maintain clinical and functional outcomes data and data to support Quality activities.* d. *Ad Hoc Reporting. Maintain the capacity to perform ad hoc reporting on an "as needed" basis, with a turnaround time as determined by the Agency.* Contract K.12(d)(f)(j)(m) Contract K.14	**HSAG Required Evidence:** • Policies, procedures, and workflows • Completed Information Systems Capabilities Assessment Tool (ISCAT) • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** Element 3a, 3b, 3c, 3d: IA_MHC_Information Technology Policy_IS-01 Whole Document Element 3.a, 3c and 3.d: IA_MHC_Molina Healthcare Health Information Application Strategy Plan 2023 Page 9 to 10 Element 3.b: IA_MHC_Molina Healthcare Health Information Application Strategy Plan 2023 Page 16	☒ Met ☐ Not Met
MCO Description of Process: The report generation components of our MIS fully support all quality and compliance-related program reporting, including standard and ad hoc, network oversight/adequacy, and call center reporting, as well as reports produced for our Population Health program. The state capitation payment 820 files are processed through our MIS system timely. Using our premium reconciliation application, we reconcile premiums received from State partners and address any discrepancies by working closely with the HHS.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface		
4. The MCO implements an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCO. Information is made accessible to its current members or the members' personal representatives through the API as follows: a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed; b. Encounter data no later than one (1) business day after receiving the data from providers compensated on the basis of capitation payments; c. All other encounter data, including adjudicated claims and encounter data from any subcontractors. d. Clinical data, including laboratory results, no later than one (1) business day after the data is received by the MCO; e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. 42 CFR §438.242(b)(5) 42 CFR §431.60 Contract K.48	**HSAG Required Evidence:** • Policies, procedures, and workflows • API project plan(s) • API documentation • HSAG will use the results from the API demonstration **Evidence as Submitted by the MCO:** Element 4.a, 4b, 4c, 4.d, and 4e: IA_MHC_Interoperability Policy_CS-03.pdf Whole document API project plan: We do not have an active project plan, since Molina healthcare interoperability has been implemented and completed. The PMO implementation project plan template is attached as an example project plan: Implementation Plan Template (IMP010S) Interoperability Product Documentation 5.80.004.000_genericOOB-IDP Whole Document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa's MIS is compliance with federal and HHS interoperability requirements outlined in Molina Healthcare of Iowa's MIS and the HHS contract K.48. Through API, member or their designated parties can obtain his/her data including but not limited to claims, encounter, clinical and drugs.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		
5. The MCO maintains a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2). 42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) Contract K.48	**HSAG Required Evidence:** • Policies, procedures, and workflows • Link to web-based provider directory(ies) • HSAG will use the results from the web-based provider directory demonstration **Evidence as Submitted by the MCO:** Element 5: IA-ME.02 Provider Directory Policy whole document Link to web-based provider directory(ies): Molina Healthcare of Iowa provider online directory is being built with a deployment date of 4/1/2023	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare of Iowa provides a provider online directory file in the required format, provider online directory search tool, and paper provider directory required by 42 CFR §431.70. The provider directory includes all the data elements required by 42 CFR §438.10(h)(1) and (2). Molina Healthcare of Iowa provider online directory is being built with a target deployment date of 4/1/2023		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		
Data Exchange and Management		
6. *The MCO shall be a full participant of the Iowa Health Information Network (IHIN) and obtain Agency approval of HIT initiatives and interfaces with IHIN.* Contract K.01	**HSAG Required Evidence:** • Policies, procedures, and workflows • Data exchange guidelines **Evidence as Submitted by the MCO:** Element 6: Molina_Iowa_HIE_Approach Whole Document Information Protection Standard_ITS-008 (1) Whole Document	☒ Met ☐ Not Met

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	IA_MHC_Molina Healthcare Health Information Application Strategy Plan 2023 Page 4 and 17 MolinaADT-DataFlow Whole Document Molina_HIE_ADT_APISpecification_Draft Whole Document	
MCO Description of Process: Molina Healthcare will be in full participation of HHS IHIN and will obtain HHS approval of any HIT initiatives and interfaces with IHIN.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		
7. *The MCO's IS shall support and maintain compliance with current and future versions of HIPAA Transaction and Code Set requirements for electronic health information data exchange and Privacy and Security Rule standards as specified in 45 C.F.R. Parts 160, 162 and 164. The Contractor's IS plans for privacy and security shall include, but not be limited to: (i) administrative procedures and safeguards (45 C.F.R. § 164.308); (ii) physical safeguards (45 C.F.R. § 164.310); and (iii) technical safeguards (45 C.F.R. § 164.312).* Contract K.18	**HSAG Required Evidence:** • Policies, procedures, and workflows • Data exchange guidelines • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** Element 7: IA_MHI HP 35 - HIPAA Transactions Compliance.pdf Whole Document IA_MHI HP 36 - HIPAA Code Sets Compliance 02-28-22.docx.pdf Whole Document Data exchange guidelines: IA_MCO Interface Guide_NEW_02102023 Whole Document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare maintains full compliance with applicable legal and regulatory standards when conducting transactions covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
8. *All data shared by the MCO with HHS uses the format specified by HHS including use of valid values that will be accepted by each code field.* Contract K.38	**HSAG Required Evidence:** • Policies, procedures, and workflows • Data exchange guidelines • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** Element 8: IA_MHI HP 35 - HIPAA Transactions Compliance.pdf Page 2 IA_MHC_Molina Healthcare Health Information Application Strategy Plan 2023 Page 7 IA_MCO Interface Guide_NEW_02102023 Whole Document IA_File Layouts Summary 2-10-23 Whole Document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare will comply to the joint interface plan developed by HHS, by following required file format, including any valid values code sets.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		
9. *The MCO must submit Provider Network information via electronic file to the Agency in the time frame and manner defined by the Agency. The MCO must keep Provider enrollment and Disenrollment information up to date.* Contract K.40	**HSAG Required Evidence:** • Policies, procedures, and workflows **Evidence as Submitted by the MCO:** Element 9: Standard XIII - Health Information Systems Data Exchange draft Whole Document	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare will submit provider network file to HHS following the state required layout and frequency.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The MCO provided the testing plan with HHS for the exchange of the Master Provider File and indicated that testing was successful for loading the provider data to the MCO's systems. However, it was not clear whether the MCO has not yet received the Waiver Provider and Services File from HHS or conducted testing to ensure the appropriate exchange and loading of this provider data.		
Required Actions: In order to receive a *Met* score, the MCO must provide confirmation that Molina is prepared to receive the Waiver Provider and Services File from HHS and will follow a similar testing process for the exchange and loading of this information.		
Third Party Liability		
10. *The MCO exercises full assignment rights as applicable and makes every reasonable effort to determine the liability of third parties to pay for services rendered to members under the Contract and cost avoid and/or recover any such liability from the third party.* a. *The MCO develops, implements, and adheres to policies and procedures to meet its obligations regarding third party liability (TPL) when the third party pays a cash benefit to the member for medical claim expenses, regardless of services used, or does not allow the member to assign their benefits.* b. *When there is a liable third party, the MCO pays the member's coinsurance, deductibles, co-payments, and other cost-sharing expenses up to the MCO's allowed amount.* c. *The MCO's total liability does not exceed the MCO's allowed amount minus the amount paid by the primary payer.* d. *The MCO follows all activities laid out in the most recent HHS Medicaid TPL Action Plan, and most recent CMS handbook called Coordination of Benefits and Third-Party Liability (COB/TPL) In Medicaid.* Contract J.4.02	**HSAG Required Evidence:** • Policies, procedures, and workflows • TPL processing guidelines • HSAG will use the completed ISCAT and results from the claims testing **Evidence as Submitted by the MCO:** Element 10a, 10b, 10c, 10d: IA_PI-TPL-002 - TPL Cost Avoidance Whole Document IA_PI-TPL-002 - TPL Cost Avoidance Procedure Whole Document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare will ensure that Medicaid is the payer of last resort in accordance with Coordination of Benefits (COB) federal and HHS mandates. Payment Integrity is responsible for the identification and validation of TPL coverage that is the primary payer over Medicaid.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Payment Integrity manages the various sources of TPL data and their ingestion into the claim processing system to pay or deny claims due to coordination of benefits during claim adjudication.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		
Continuity and Contingency Planning		
11. *The MCO must develop plans for system problem resolution that do not rise to the level of Disaster and document such in its PPM.* a. *The MCO must notify the Agency immediately upon identification of network hardware or software failures and sub-standard performance and shall conduct triage with the Agency to determine the severity level or deficiencies or defects and determine timelines for fixes.* b. *The MCO must develop, implement, and adhere to procedures defining the methods for notifying the Agency and other applicable stakeholders regarding system problems that do not rise to the level of Disaster as defined in Section K.35.* Contract K.31 Contract K.32	**HSAG Required Evidence:** • Policies, procedures, and workflows • IS contingency plans **Evidence as Submitted by the MCO:** **Element 11a and 11b** Business Continuity and Disaster Recovery Standard_ITS-003 Page 7 MOLINA HEALTHCARE OF IOWA SYSTEM SYSTEM PROBLEM RESOLUTION, ESCALATION AND CHANGE MANAGEMENT PLAN.docx Page 1 and Page 2 Molina Healthcare of Iowa (MHI_IA) Business Continuity Plan Page 12	☒ Met ☐ Not Met
MCO Description of Process: MIT major incidence notification has been built into our business continuity plan. HHS will be notified per the process outlined.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
12. *The MCO develops and submits contingency and continuity planning documents and documents such in its PPM. In addition, the MCO ensures ongoing maintenance and execution of the HHS-accepted contingency and continuity plans. The MCO's contingency and continuity planning responsibilities include, but are not limited to:* a. *Notifying HHS of any disruptions in normal business operations with a plan for resuming normal operations.* b. *Ensuring members continue to receive services with minimal interruption.* c. *Ensuring data is safeguarded and accessible.* d. *Training MCO staff and stakeholders on the requirements of the information system contingency and continuity plans.* e. *Conducting annual exercises to test current versions of information system contingency and continuity plans.* i. *The scope of the annual exercises are approved by HHS.* ii. *The MCO provides a report of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercises.* Contract K.35(b)	**HSAG Required Evidence:** • Policies, procedures, and workflows • IS contingency plans **Evidence as Submitted by the MCO:** Element 12a: MOLINA HEALTHCARE OF IOWA SYSTEM SYSTEM PROBLEM RESOLUTION, ESCALATION AND CHANGE MANAGEMENT PLAN.docx Page 1 and Page 2 Molina Healthcare of Iowa (MHI_IA) Business Continuity Plan Page 12 Elements 12b: Business Continuity and Disaster Recovery Standard_ITS-003 Page 6 Molina Healthcare of Iowa (MHI_IA) Business Continuity Plan Whole Document Elements 12c: Business Continuity and Disaster Recovery Standard_ITS-003 Page 9 MHI Disaster Recovery Plan - 2022 v4.8 Page 20 and 23 Elements 12d, 12e: Molina Healthcare of Iowa (MHI_IA) Business Continuity Plan Page 3	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare Business Continuity Plan (BCP) outlines the steps required to operate in the event of an unanticipated interruption of normal operations. It will identify the business processes that need to be restored and the strategies to do so.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
13. *The MCO develops IS contingency planning in accordance with 45 CFR §164.308. Contingency plans include:* a. *Data Backup plans;* b. *Disaster Recovery plans;* c. *Emergency Mode of Operation plans.* Contract K.36	**HSAG Required Evidence:** • Policies, procedures, and workflows • IS contingency plans **Evidence as Submitted by the MCO:** Element 13a: MHI Disaster Recovery Plan - 2022 v4.8 Page 11 Element 13b: MHI Disaster Recovery Plan - 2022 v4.8 Whole Document Element 13c: MHI Disaster Recovery Plan - 2022 v4.8 Page 21 Element 13a, 13b, 13c: Business Continuity and Disaster Recovery Standard_ITS-003 Whole Document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare Disaster Recovery Plan (DRP) is designed to provide response and recovery procedures from major events that would result in the loss of critical processing capabilities at MHIs primary Data Center located in Azure South Central. The DRP covers the requirements, strategy and process to provide for a smooth transition of critical functions to the alternate data center in Azure North Central to resume normal business operations. It has all the components required by 45 CFR §164.308 for contingency plan.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		
14. *The MCO's Application and Data Criticality Analysis and Testing and Revisions procedures are also addressed within the required contingency plans.* a. *The MCO executes all activities needed to recover and restore operation of information systems, data, and software at an existing or alternate location under emergency conditions within twenty-four (24) hours of identification or a declaration of a Disaster.* b. *The MCO protects against hardware, software, and human error.*	**HSAG Required Evidence:** • Policies, procedures, and workflows • IS contingency plans **Evidence as Submitted by the MCO:** Element 14a, 14b, 14c Business Continuity and Disaster Recovery Standard_ITS-003 Whole Document MHI Disaster Recovery Plan - 2022 v4.8 Whole Document 2022-11-05 MHI Claims Processing DR Report Whole Document	☒ Met ☐ Not Met

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
c. *The MCO maintains appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups, and disaster recovery.* Contract K.36		
MCO Description of Process: Molina Healthcare Disaster Recovery Plan addresses all element 14 requirements fully.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		
15. *The MCO maintains full and complete back-up copies of data and software in accordance with the timelines described in Section K.13 of the Contract.* a. *The MCO maintains a back-up log to verify the back-ups were successfully run and a back-up status reports are provided to HHS upon request.* b. *The MCO stores its data in an off-site location approved by HHS.* Contract K.37	**HSAG Required Evidence:** • Policies, procedures, and workflows • IS contingency plans **Evidence as Submitted by the MCO:** Element 15a: MHI Disaster Recovery Plan - 2022 v4.8 Page 12 IA_MHC_Molina Healthcare Health Information Application Strategy Plan 2023 Page 17 Business Continuity and Disaster Recovery Standard_ITS-003 Whole Document Element 15b: MHI Disaster Recovery Plan - 2022 v4.8 Page 11 IA_MHC_Molina Healthcare Health Information Application Strategy Plan 2023 Page 17 Business Continuity and Disaster Recovery Standard_ITS-003 Whole Document	☒ Met ☐ Not Met
MCO Description of Process: Molina Healthcare Disaster Recovery Plan includes logging of all backup run and status. Data is stored in the off-site location. We will provide the DR testing reports and backup logs to HHS upon request and will obtain approval from HHS for backup site location.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
16. *The MCO must develop processes for development, testing, and promotion of system changes and maintenance.* a. *The MCO must notify the Agency at least thirty (30) Days prior to the installation or implementation of "minor" software and hardware upgrades, modifications, or replacements, and ninety (90) Days prior to the installation or implementation of "major" software and hardware upgrades, modifications, or replacements.* b. *The MCO must ensure that system changes or system upgrades are accompanied by a plan that includes a timeline, milestones, and adequate testing to be completed before implementation. The MCO must notify and provide such plans to the Agency upon request in the time frame and manner specified by the Agency. The MCO must develop and submit the plan required under this section in its PPM.* c. *The Contractor shall ensure the environment for development, system testing and UAT is separate from the production environment.* Contract K.33 Contract K.34	**HSAG Required Evidence:** • Policies, procedures, and workflows • IS testing plan • Technical manual(s) • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** Element 3a, 3b: MOLINA HEALTHCARE OF IOWA SYSTEM SYSTEM PROBLEM RESOLUTION, ESCALATION AND CHANGE MANAGEMENT PLAN.docx Page 3 Element 3c: Change Management Standard_ITS-005 (2) Page 6 Change Management Process v20.4.1 Technical Manual Whole Document IS testing plan: Change testing is outline in Change Management Standard_ITS-005 (2) section 1.3 Change Management Testing. In addition, Molina Healthcare PMO testing plan template has been provided as evidence: Project Test Plan (TST010)	☒ Met ☐ Not Met
MCO Description of Process: Molina will ensure that any system changes or system upgrades are accompanied by a plan that includes a timeline, milestones, and adequate testing to be completed before implementation. Molina will notify and provide such plans to Iowa Medicaid upon request in the timeframe and manner specified by Iowa Medicaid. For application development, development, testing, uat and production environments are separated from each other.		
HSAG Findings: HSAG has determined that the MCO provided sufficient evidence and adequate systems to support readiness with the requirements of this element.		
Required Actions: None.		

Standard XIII—Health Information Systems						
Met	=	13	X	1	=	13
Not Met	=	3	X	0	=	0
Total	=	16	Total Score		=	13
				Total Score ÷ Total	=	81%

Appendix D. Information Systems Test Claim Scenarios

Information Systems Claims Scenarios Tool—Test Claims Scenarios *for* Professional Services								
Scenario	**Member #**	**Claim Scenario**	**Date of Service**	**Provider Name**	**Claim Type**	**Suggested Service Codes, Modifiers**	**Diagnosis Code(s)**	**Place of Service (POS) Code**
1	8	Member selects new MCO in third trimester; prenatal office visit-third trimester.	11/05/22	Kate Austin, MD	1500	59025, 76815	A21.2, G43.909, Z3A.36, A18.31	11
2	8	Laboratory services related to prenatal visit.	11/05/22	Legacy Labs	1500	86850, 85025, 82950	Z01.89	81
3	1	Child receives early and periodic screening, diagnostic and treatment (EPSDT) services.	04/12/22	Wesley Williams, MD	1500	99382-EP	Z00.129	11
4	1	Infant becomes ill and requires a visit to the primary care provider (PCP) and receives a prescription for antibiotics.	04/19/22	Wesley Williams, MD	1500	99213	H65.03	11
5	2	Child receives parenteral nutrition and supplies.	08/08/22	Pinewood Infusion, LLC	1500	B4035, B4160, B9002-RR	K90.0, R62.51	12
6	3	Ear, Nose, and Throat (ENT) specialist consultation.	07/29/22	Spencer Reid, MD	1500	99244	H69.93, H66.93, R50.9	11
7	4	Child sees psychologist for assessment and evaluation for attention deficit hyperactivity disorder (ADHD).	02/22/23	Grace Miller, PsyD	1500	99205	F90.1	11
8	18	Child receives eye examination and receives corrective glasses.	020/3/23	Optical Illumination, PC	1500	92014, 92002	Z01.01	11

Information Systems Claims Scenarios Tool—Test Claims Scenarios *for* Professional Services								
Scenario	**Member #**	**Claim Scenario**	**Date of Service**	**Provider Name**	**Claim Type**	**Suggested Service Codes, Modifiers**	**Diagnosis Code(s)**	**Place of Service (POS) Code**
9	5	Upon Emergency Department (ED) discharge, child referred to endocrinologist for urgent evaluation and treatment. Prior authorization was not obtained.	05/05/22	Arturo Suarez, MD	1500	99204, 36416, 82951	E10.65, R55	11
10	15	Second dose of Pfizer COVID vaccine for Dual-Eligible member by pharmacist in retail pharmacy.	08/30/22	Carson Retail Pharmacy	1500	91300, 0002A	z28.311	01
11	9	Claims for series of behavioral health counseling sessions post-discharge from hospital.	1st Visit: 05/22/22 2nd Visit: 05/26/22 3rd Visit: 05/30/22	Ellen D. Generous, MSW	1500	90791 (1st visit), 90837 (2nd & 3rd visits), 90875 (can be used with all 3 codes)	F32.9, F50.00	11
12	10	Substance use disorder therapy claims.	08/29/22 09/06/22 09/13/22 09/20/22 09/27/22	Ellen D. Generous, MSW	1500	H0004 (bill 5 sessions)	F11.12, B18.2	11
13	12	Pre/post natal care (no delivery) - non-par provider with whom member has prior fee-for-service (FFS) claims as treated by provider during pregnancy.	03/31/22	Maya Naturaleza, MD	1500	59426	Z34.00, Z60.3	11
14	13	Ventilator dependent quadriplegic develops cellulitis and requires emergency transportation to hospital.	09/19/22	Stagecoach Express Ambulance	1500	A0429	L03.90, Z99.11	41

Information Systems Claims Scenarios Tool—Test Claims Scenarios *for* Professional Services								
Scenario	**Member #**	**Claim Scenario**	**Date of Service**	**Provider Name**	**Claim Type**	**Suggested Service Codes, Modifiers**	**Diagnosis Code(s)**	**Place of Service (POS) Code**
15	14	Bariatric surgeon claim for gastric sleeve surgery.	07/17/22	Leo Spaceman, DO	1500	43775	Z68.34, Z00.8, E66.01	21
16	15	Durable medical equipment (DME) for walker and other safety devices for Dual-Eligible member.	06/28/22	Golden Nugget DME	1500	E0144, E0240, E0244	Z91.81, Z60.2	12
17	7	Face-To-Face Behavioral Counseling	11/07/22	Tribal Health Center	1500	G0443 (4 units)	F32	05
18	17	PCP well-care visit.	02/26/22	Beverly Marsh, MD	1500	99396, 99213-25, 99406, 71046	Z00.01, R06.02, F17.210	11
19	12	Expectant mom goes to birthing center to deliver. After a prolonged labor, the patient is transferred to the hospital to reduce risk to the mother and baby.	06/25/22	Crystal Bay Birthing Center	1500	99212-TH, 99354-TH, 99355-TH (X 4), 59020-TC, 59020-26, S4005	Z34.00, Z60.3, O66.40	25

Information Systems Claims Scenarios Tool—Test Claims Scenarios *for* Institutional Services								
Scenario	**Member #**	**Claim Scenario**	**Date of Service**	**Provider Name**	**Claim Type**	**Suggested Codes**	**Diagnosis Code(s)**	**POS Code**
1	8	Ultrasound - outpatient.	Day 6	Mercy Medical Center	UB04	0402, 76811	Z3A.36, Z36.3	22
2	8	Hospital delivery.	Day 15	Mercy Medical Center	UB04	0122, 0250, 0251, 0258, 0300, 0302, 0305, 0450, 0722	O14.03, D62, O80, Z37.0	21
3	5	Child is seen in emergency room for lethargy, blurred vision, irritability, and weight loss.	06/08/22	Mercy Medical Center	UB04	0260, 0301, 0300, 0762, 0450, 0258, 0301, 0301, 0301	E10.65, E08.65, R55	23
4	6	Hospital asthma treatment.	08/07/22	Mercy Medical Center	UB04	0123, 0412	J45.51, Z91.120, Z91.89	21
5	9	Emergency Department (ED) visit for suicide attempt.	05/07/22	Mercy Medical Center	UB04	0301, 0450, 0307, 0305	F32.9, R45.851, F50.00, T14.91XA	23
6	9	Inpatient admission to psychiatric ward.	05/08/22	Mercy Medical Center	UB04	0114	F32.9, R45.851, F50.00	21
7	10	Claim for hospital stay.	01/14/23	Mercy Medical Center	UB04	0301, 0305, 0120	B19.10, R50.9	21
8	11	Multiple ED claims.	03/22/22	OON ED	UB04	0450, 0300, 0310, 0250	M54.5, F45.41	23

Information Systems Claims Scenarios Tool—Test Claims Scenarios *for* Institutional Services								
Scenario	**Member #**	**Claim Scenario**	**Date of Service**	**Provider Name**	**Claim Type**	**Suggested Codes**	**Diagnosis Code(s)**	**POS Code**
9	14	Inpatient claim for gastric sleeve surgery.	09/17/22	Mercy Medical Center	UB04	0151, 0300, 0301, 0305, 0310, 0710	Z68.34, Z00.8, E66.01, I10	21
10	13	Ventilator dependent quadriplegic receives full-time care at nursing facility and has client participation requirement of $925.	10/01/22–10/28/22	Palms Desert Care Center	UB04	0194 (Type of Bill=212)	Z99.11	32

Information Systems Claims Scenarios Tool—Test Claims Scenarios *for* Institutional Services (LTSS Services)								
Scenario	**Member #**	**Claim Scenario**	**Date of Service**	**Provider Name**	**Claim Type**	**Suggested Service Codes**	**Diagnosis Code(s)**	**POS Code**
1	19	Elderly Waiver Member needs Home Health Services— 8 hr per day	04/24/22–04/29/22	Four Queens Home Health Agency	1500	T1021	J44.1, I50.32	12
2	19	Elderly Waiver Member needs Nursing—1 visit per day	05/02/22–05/07/22	Four Queens Home Health Agency	1500	T1030	J44.1, I50.32	12
3	20	Waiver Member with Brain Injury needs Specialized Medical Equipment—lift chair	03/28/22	Golden Nugget DME	1500	T2029	R41.843, H54, Z87.820	12
4	20	Waiver Member with Brain Injury needs Transportation—1 trip (15 trips authorized)	07/07/22	Rides R Us	1500	S0215	R41.843, H54, Z87.820	99

Information Systems Claims Scenarios Tool—Test Claims Scenarios *for* Pharmacy Services							
Scenario	**Member #**	**Claim Scenario**	**Fill Date**	**Ordering Provider**	**Claim Type**	**Description of Medications**	**Pharmacy**
1	1	Infant prescribed antibiotic for infection.	05/03/22	Wesley Williams, MD	RX	Amoxicillin: 1/2 tsp (2.5ml) tsp. bid (twice/day), (7, 10, or 14 day supply).	Wynn
2	4	Attention Deficit Hyperactivity Disorder (ADHD) medications.	12/22/22	Jeffrey John, MD	RX	Adderall XR: 10 mg. once a day in a.m. (90 days supply)	Wynn
3	5	Prescription/RX for insulin.	05/05/22	Physician at ABC Health Center	RX	NovoLog 100 U/mL: 10 units per day. Basis of Cost Determination = 08; Submission Clarification Code = 20	Carson
4	6	Prescription/RX claims for inhalers and corticosteroids.	09/12/22	Wesley Williams, MD	RX	Pulmicort Respules (budesonide) : Oral corticosteroids 0.5 mg. twice daily; Singulair chewable tablet, 4 mg. Chew one tablet daily at bedtime.	Carson
5	9	Prescription/RX claims for antidepressants and other medications.	05/10/22	Hospitalist - Discharge Medications	RX	Fluoxetine (Prozac) 10 mg: One tablet daily; Zyprexa 10 mg.: One tablet daily.	Wynn
6	10	Prescription/RX for antiviral and addiction medications.	01/30/23	Bruce Bannerman, MD	RX	Sovaldi: 400 mg. and Ribavirin: 600 mg. once a day; Buprenorphine/Naloxone: 11.4mg./2.9 mg. sublingually as a single dose.	Wynn
7	11	Prescription/RX claims for narcotics.	03/22/22	Howard Sheinfield, MD	RX	Morphine sulphate: 60 mg., every 4 hours; 30 day supply.	Wynn
8	16	Prescription/RX claims for antipsychotic medications and prednisone.	09/14/22	Psychiatrist	RX	Abilify: 10 mg. once daily (no substitution permitted); Prednisone 20 mg. orally three times (t.i.d) a day.	Wynn
9	17	Prescription/RX claims for smoking cessation medications.	02/26/22	Internal Medicine Physician	RX	Nicorette gum: 2 mg., chew 1 piece every 2 hours (q2h); 90 day supply.	Carson
10	18	Patient with severe peanut allergy requires EpiPen for school.	08/11/22	Wesley Williams, MD	RX	EpiPen Jr. 2-Pak.	Wynn

Information Systems Claims Scenarios Tool—Test Claims Scenarios *for* Pharmacy Services							
Scenario	**Member #**	**Claim Scenario**	**Fill Date**	**Ordering Provider**	**Claim Type**	**Description of Medications**	**Pharmacy**
11	18	Vitamins with fluoride.	10/17/22	Annie Cavanero, MD	RX	Vitamins with fluoride (tablets or drops); chew 1 tablet daily or 1.0 ml./day).	Wynn
12	19	Prescription/RX claim for analgesic opioid agonist for Dual Eligible member.	06/17/22	Nancy Zimmerman, MD	RX	30-day supply of Fentanyl Citrate Lozenge	Carson
13	7	Prescription/RX claim for antiretrovirals.	12/17/22	Beverly Marsh, MD	RX	Invirase 500 mg twice daily, Ritonavir 100 mg twice daily (7 day supply)	Carson

Appendix E. Information Systems Readiness Review Remediation Plan

Information Systems Readiness Review Standards Remediation Plan		
Standard I—Enrollment Systems—Requirement 2		
Requirement 2: Interface with State Systems and Member Enrollment Data—The MCO's information systems shall have the capacity to electronically receive HIPAA-compliant 834 enrollment files through a file transfer process with the Agency's Title XIX eligibility system in a manner, time frame, and frequency determined by HHS. a. Extraction, transformation, and load (ETL) processes used by the MCO must be documented in detail and approved by HHS. b. The MCO must report inability to retrieve or load eligibility data for any reason to the sending trading partner and the Agency on the same business day as transmission. c. The MCO must not modify Enrolled Member identifiers, eligibility categories, or other Enrolled Member data elements without written approval from the Agency. *The MCO should describe, in detail, how it processes enrollment, disenrollment, and changes to the recipient's enrollment information in the MCO's systems from the daily and monthly enrollment files provided by HHS. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.*		
***Reference**—HHS Contract Sections K.26. and K.39(a)*		
Score:	☐ Met	☒ Not Met—Action Required
Findings:	The MCO submitted policies and procedures that described the process of loading enrollment data into its system and indicated during the site review that member services staff only have the ability to update a member's address for 90 days. The MCO indicated that enrollment staff have the ability to edit member data in QNXT to ensure that the data match the 834 file as the source of truth, and it has multiple audit reports to ensure that data loaded in QNXT match the raw 834 files received from HHS. The IA_EnrollmentandEligibility policy included language that meets Requirement 2a and 2b. However, the MCO did not provide evidence that its ETL processes were documented in detail and approved by HHS as stated in Requirement 2a.	
Required Action:	In order to receive a *Met* score, the MCO must: • Provide evidence that Molina submitted detailed documentation of its ETL processes for HHS approval. • Provide the testing plan and status of testing with HHS for the exchange of 834 enrollment files.	

Information Systems Readiness Review Standards Remediation Plan	
Standard I—Enrollment Systems—Requirement 2	
Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
MEG_PROCESS_FLOW_DIAGRAM IA _Enrollment and Disenrollment PnP IA _Molina Overall Systems v4 IA_In834NotInQNXT_Report IA_InQNXTNoton834_Report IA _Enrollment and Eligibility	*HIPAA 834 monthly enrollment files are full replacement files and show current status for each Member. Our process reads each record and validates the information currently in our system. If a change is found, the system is updated with the new information. Daily eligibility files contain new, changed, and terminated Members, whose information we load into QNXT before the next business day. As part of our standard process, we reconcile the data on each file with what is loaded in our eligibility and enrollment system, check for duplication, and discrepancies are sent to Molina Member Workflow (MMW) for our Enrollment team's review.* *If exceptions are generated during any part of the enrollment data load, including 834 file load, PCP assignment, and vendor extracts, an exception is generated. The exception is then made available to the Enrollment team and in our Member Workflow to resolve the conflict and process the record.*
Plan to Remedy Deficiency: Molina Healthcare of Iowa submitted the document (previously uploaded to SAFE) "MEG_ETL_PROCESS_FLOW_DIAGRAM.pdf" to HHS on May 25, 2023, for approval and uploaded the HHS submission email "State Material Submission 1253 - MEG_ETL PROCESS_FLOW_DIAGRAM" to SAFE. Please see the documents titled "Testing Cycle 4 834 Scenarios" and the "MHIA 834 State Testing Plan" which have been uploaded to SAFE, for the cycle 4 testing plan. Please note, Molina Healthcare of Iowa is currently processing enrollment data into its pre-production environment based upon the 834 files received on May 26, 2023.	
Individual(s) Responsible: Michael Wharton and Jeff Cangialosi	
Completion Date: 5/26/23	
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.	☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Information Systems Readiness Review Standards Remediation Plan		
Standard I—Enrollment Systems—Requirement 5		
Requirement 5: Managed Care Excluded Populations—The populations in this section are excluded from enrollment in the Medicaid managed care program. a. Non-qualified aliens receiving time-limited coverage of certain Emergency Medical Conditions. b. Beneficiaries who have a Medicaid eligibility period that is retroactive. c. Persons eligible for the PACE who voluntarily elect PACE coverage. d. Persons enrolled in HIPP. e. Persons deemed Medically Needy. f. Persons incarcerated and ineligible for full Medicaid Benefits. g. Persons presumed eligible for services (i.e., Presumptive Eligibility). h. Persons residing in the Iowa Veteran's Home. i. Effective July 1, 2017, beneficiaries who are eligible only for the Family Planning Waiver. j. Persons eligible only for the Medicare Savings Program. k. Alaskan Native and American Indian populations shall be enrolled voluntarily. *The MCO should describe its processes for ensuring that enrollment data received and processed into its enrollment data system is for populations eligible for the managed care program only and should describe its process for communicating any issues with or discrepancies in enrollment data to HHS. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.*		
***Reference**—HHS Contract Exhibit D*		
Score:	☐ Met	☒ Not Met—Action Required
Findings:	The MCO submitted a policy that indicates these populations are excluded from managed care and indicated during the site review that they would not be loaded into QNXT due to rate codes that would not pass the MCO's validation process; however, the policy indicated that HHS was responsible for ensuring that these consumers are not included on the 834 files rather than describing how the MCO would handle a situation in which one of these consumers was included on an 834 file.	
Required Action:	In order to receive a *Met* score, the MCO must provide the updated IA_Included and Excluded Populations policy that describes the steps the MCO would take or system controls used to ensure that these consumers would not be loaded into the MCO's systems during the 834 loading process and how the MCO would notify HHS of the consumers being included on the file.	

Information Submitted as Evidence by the MCO	
Documents Submitted	**Description of the Process**
IA _Included and Excluded Populations pgs. 3-4	*Members that are included in the excluded populations are not sent on the 834 extract and therefore are not enrolled into the MCO. The MCO enrolls members that have met the States requirements and are sent on the daily and*

Information Systems Readiness Review Standards Remediation Plan	
Standard I—Enrollment Systems—Requirement 5	
	monthly extract. If at any time during enrollment, the MCO learns of member being part of the managed care excluded population, departments will route disenrollment request through the Enrollment and Government Contracts teams to the State agency.
Plan to Remedy Deficiency: Molina Healthcare of Iowa has updated the policy and procedure for "IA_Included and Excluded Populations revised May 22, 2023" to ensure that a process is in place should Molina receive any ineligible members on the 834 file. This updated policy and procedure will ensure that Molina will only load members that are eligible for Molina Healthcare into our systems. The "IA_Included and Excluded Populations revised May 22, 2023" policy and procedure document has been uploaded to SAFE.	
Individual(s) Responsible: Rich Russell and Erica Tims-Sewell	
Completion Date: 5/22/23	
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.	☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Information Systems Readiness Review Standards Remediation Plan		
Standard II—Claims and Encounter Systems—Requirement 1		
Requirement 1: Claims Processing and Encounter Systems—The MCO must have a claims processing system and Management Information System (MIS) that: a. Collects data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission) in accordance with section 6504(a) of the Affordable Care Act. The MCO must provide electronic remittance advice and transfer claims payment electronically. The MCO must have the capacity to process paper claims and track electronic versus paper claim submissions over time to measure success in increasing electronic submissions. The MCO must be able to maintain data on incurred but not yet reimbursed claims and data on the time required to process and mail claims payment. The MCO must be able to submit daily files of pre-adjudicated claims (i.e., shadow claims) that were received on the previous day to HHS in 837I and 837P formats. b. Enables the MCO to manage and monitor its system to ensure collection of encounter data received from providers is accurate and timely; screen the data for completeness, logic, and consistency; and collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in accordance with 42 CFR 438.242(b) and (c). Include a description of the process utilized when a capitated provider fails to submit encounters or submits encounters without paid claims. c. Collects and maintains data on member and provider characteristics as specified by HHS, and on services furnished to the recipients through an encounter data system or other method as may be specified by HHS. The MCO must be able to generate information specific to service type, including but not limited to: (i) Behavioral Health Services; (ii) LTSS; (iii) pharmacy; (iv) inpatient services; and (v) outpatient services. The MCO makes all collected data available to HHS and upon request to CMS. d. Accommodates billing of LTSS recipients a predetermined Client Participation amount for the cost of LTSS services and process claims in accordance with the participation amount and pay providers the net of the applicable Client Participation amount. The MCO must implement a mechanism to establish which provider the enrolled member is to pay their Client Participation on a monthly basis. e. Accommodates billing of specified enrolled members a cost sharing amount and reduce the payment it makes to a provider by the amount of the member's cost sharing obligation. The MCO must implement a mechanism to notify providers of an enrolled member's financial participation or cost sharing requirement. *The MCO should provide a description of its systems for managing the claims processing and encounter data requirements. Evidence includes process flows, policies and procedures, system manuals, process manuals, etc.*		
***Reference**—42 CFR 438.242; HHS Contract Sections K.04, K.05, K.06, K.07, K.09, K.10(a), K.12(g)(h)(o) and K.41*		
Score:	☐ Met	☒ Not Met—Action Required
Findings:	The policies and procedures submitted for this requirement indicate that the MCO's processes for claims adjudication, validation procedures for ensuring claims and encounter files meet requirements, and that auditing/monitoring process to ensure accuracy meet this requirement. The MCO demonstrated during the site review that it has sufficient processes in place to monitor timeliness of claims adjudication. The	

Information Systems Readiness Review Standards Remediation Plan		
Standard II—Claims and Encounter Systems—Requirement 1		
	MCO also demonstrated in its test environment that the claims system is fully configured to adjudicate all claims using Iowa billing requirements. However, the system has not yet been deployed to the production environment for the Iowa Medicaid managed care program.	
Required Action:	In order to receive a *Met* score for this element, the MCO must: • Provide confirmation that its claims payment system is live during the June 2023 system demonstration.	
Information Submitted as Evidence by the MCO		
Documents Submitted	**Description of the Process**	
1a. IA _MHC _Molina Healthcare Health Information Application Strategy Plan 2023 Page 1 to 7 and Page 11 to 14. 1b. Claim and Encounter Submission Methods- All States and LOBs-SOP 1b. Encounters Report Monitoring- All States and LOBs- SOP 1c. Claims Encounters Management System for Encounter Data Compliance 1c. IA SOP Reporting Approach Strategy and Delivery 1d. IA CP Workflow 1d. IA Claim- 110 MLTSS ClientPartPolicy-23 1e. IA Copayment Policy	*Molina Healthcare of Iowa, Inc. (Molina) is compliant with 42 CFR 438.242 and the Iowa Health Link contract. Molina and Iowa Health and Human Services (HHS) are meeting on 2/22/2023 to discuss the shadow claims process.*	
Plan to Remedy Deficiency: Molina Healthcare of Iowa confirms that our core claims payment system will be live in production for demonstration on June 16, 2023. Molina will provide confirmation to HSAG of live production status of our core claims system as part of that demonstration.		
Individual(s) Responsible: Rich Russell, Michael Wharton, and Jeff Cangialosi		
Completion Date: 6/16/23		
HSAG Feedback: The MCO's remediation plan is sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Systems Requirements		
1. The MCO maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to: a. Utilization b. Claims c. Grievances and appeals d. Disenrollments for other than loss of Medicaid eligibility 42 CFR §438.242(a) Contract K.02 Contract K.03	**HSAG Required Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Completed Information Systems Capabilities Assessment Tool (ISCAT) • Technical manual(s) • List of disenrollment codes (i.e., reasons for disenrollment) provided by HHS • Screenshot of disenrollment codes available in the disenrollment system • HSAG will use the results from the information systems demonstration, including reporting capabilities • HSAG will use the results from the systems demonstrations included as part of the Disenrollment Requirements and Limitations Standard, Coverage and Authorization of Services Standard, and the Grievance and Appeal Systems Standard **Evidence as Submitted by the MCO:** IA_MHC_Molina Healthcare Health Information Application Strategy Plan 2023 Page 1 to 7; System integration mapping is located on page 2 of the strategy plan. IA_MHC_Information Technology Policy_IS-01 Whole Document Technical Manuals:	☐ Met ☒ Not Met

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	Element 1a: IA HCS-325.01 Service Authorization Procedure_IA RR Whole Document Element 1b: Claims Processing Overview - All States and LOBs – SOP Whole Document Element 1c: IA _Standard Grievance SOP and IA_Appeals Core Procedure Whole Document Element 1d: IA_Enrollment and Disenrollment PnP Whole Document Molina Healthcare will use state 834 as the source of truth for member eligibility. HHS does not supply disenrollment code on the state 834, therefore Molina Healthcare cannot provide list of disenrollment code and screen shot.	
MCO Description of Process: Molina Healthcare of Iowa, Inc.'s ("Molina Healthcare of Iowa") fully integrated Management Information System (MIS) is built as the health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. It supports all Molina Healthcare operation and HHS health plan health information system requirements including claims, UM, appeals & grievances, and disenrollments.		
HSAG Findings: The MCO provided policies and procedures related to service authorization (utilization), claims processing, grievances and appeals management, and member enrollment and disenrollment. The Molina Healthcare Health Information Application Strategy Plan 2023 document included a table that lists the health information systems and applications the MCO uses to manage healthcare utilization (service review, prior authorization), claims, grievances and appeals, member eligibility (enrollment and disenrollment), and reporting requirements. Additionally, the document included workflow diagrams of processes and systems along with additional diagrams provided. However, it was unclear from the IA_Medicaid Information Systems diagram the function of all systems represented on the diagram and the timing of automated data feeds between systems. It was also unclear whether there were any manual workarounds planned for automated data feeds that will not be operational during the first phase of the Iowa plan implementation. Of note, MCO staff members stated that HHS does not supply the reason for a member's disenrollment on the 834 file. As HHS confirmed this is accurate, this finding was not considered a deficiency.		
Required Actions: In order to receive a *Met* score, the MCO must provide either an updated diagram or description of each system's function, whether data feeds are automatic as well as the timing, and when there are manual workarounds instead of data feeds from one system to another.		

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Plan to Remedy Deficiency: Molina Healthcare of Iowa has updated the document, "IA_MHC_Molina Healthcare Health Information Application Strategy Plan 2023 updated 052223" pages 3-5, which demonstrates the timing of each automated process. These automated processes do not require manual workarounds or interventions. The document "IA_MHC_Molina Healthcare Health Information Application Strategy Plan 2023 updated 052223" has been uploaded to SAFE.		
Individual(s) Responsible: Michael Wharton and Jeff Cangialosi		
Completion Date: 5/22/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
2. *The IS implemented by the MCO shall include the following general system requirements but may not necessarily be limited to these requirements: (i) online access; (ii) online access to all major files and data elements within the IS; (iii) timely processing; (iv) daily file updates of Enrolled Member, Provider, Prior Authorization and Claims to be processed; and (v) weekly file updates of reference files and Claim payments.* a. *Edits, Audits and Error Tracking: The MCO shall employ comprehensive automated edits and audits to ensure that data are valid and that Contract requirements are met. The IS shall track errors by type and frequency and maintain adequate audit trails to allow for the reconstruction of processing events.* b. *System Controls and Balancing: The IS shall have an adequate system of controls and balancing to ensure that all data input can be accounted for and that all outputs can be validated.* c. *Back-Up of Processing and Transaction Files: The MCO shall employ the following back-up timelines: (i) twenty-four (24)*	**HSAG Required Evidence:** Policies, procedures, and workflows Completed Information Systems Capabilities Assessment Tool (ISCAT) IS contingency plans HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** Element 2.a and 2b: IA_MHC_ Information and Cybersecurity Policy_CS-01 Page 10 IA_MHC_Security Logging and Monitoring Standard_ITS-015.pdf whole document Element 2.c: IA_MHC_Information Technology Policy_IS-01.pdf Page 6	☐ Met ☒ Not Met

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
hour back-up of eligibility verification, enrollment/eligibility update process, and Prior Authorization processing; (ii) seventy-two (72) hour back-up of Claims processing; and (iii) two (2) week back-up of all other processes. Contract K.13	IA_MHC_MHI IT Disaster Recovery Plan - 2022 v4_8b.pdf whole document Element 2.a, 2.b and 2.c: IA_MHC_QNXT_Risk_Assessment_2022-12-19.xlsx whole document	
MCO Description of Process: In Molina Healthcare of Iowa's MIS, all edits and errors are logged and monitored. We have implemented a series of best industrial class system controls and balancing measures. In addition, all the data and changes are backed up per schedule based on the criticality of the information. To further demonstrate full compliance with these standards, our core administrative system QNXT system risk assessment is attached.		
HSAG Findings: While the MCO provided evidence to support it has sufficient processes to meet the requirements of this element, the MCO has yet to receive member historical files from HHS for its membership.		
Required Actions: In order to receive a *Met* score, the MCO must provide confirmation when data from other MCOs and from HHS (e.g., enrollment, prior authorizations, and historical claims) are loaded in the MCO's systems.		
Plan to Remedy Deficiency: On May 26, 2023, Molina received from HHS the following production-like files that include anticipated membership for July 1, 2023: 834 Medicaid and Hawki Full Files, LTSS & Waiver Plan File, HAB File, and a one-time CSV file with member email addresses. These files are being loaded into production systems and will be loaded by June 1, 2023. Molina will provide confirmation to HSAG when the May 26, 2023 files have been loaded into Molina's systems. Recognizing these are production-like files, and at HHS' direction, Molina will attest to deleting from all Production systems any member information we receive on the prod-like files that is not on the prod files received June 26, 2023. As is reflected in the MCO warm hand-off plan, we will receive a list of files noted as "priority 1" by June 5, 2023 and files noted as "priority 2" files by June 10, 2023 from the other MCOs. Molina will provide confirmation to HSAG when the other Iowa MCO files have been loaded into Molina's systems. Consistent with the applicable State guidance, and to be 100% certain Molina can fulfill the State's clear expectations of purging specified, protected data from our systems, any such data received from the other MCOs will be maintained by Molina outside of the production systems. Once Molina receives and loads the July monthly eligibility files from the State, scheduled for June 26, 2023, Molina will load any member information received from the MCOs during the warm hand-off period into our production systems for only those members who are active with Molina effective July 1, 2023. This would include active prior authorizations and care management records.		
Individual(s) Responsible: Michael Wharton and Jeff Cangialosi		

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Completion Date: 7/1/23		
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area. However, HSAG recommends that the MCO prioritize the loading of the production enrollment file on June 26, 2023, into the live QNXT production environment and downstream systems. The MCO must provide HSAG with confirmation that the production enrollment file was successfully loaded. Additionally, the MCO is required to provide HSAG with confirmation that the files received from the other MCOs that are confirmed to be for members enrolled effective July 1, 2023, were successfully loaded into Molina's production systems during the warm hand off period starting June 26, 2023.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Data Exchange and Management		
9. *The MCO must submit Provider Network information via electronic file to the Agency in the time frame and manner defined by the Agency. The MCO must keep Provider enrollment and Disenrollment information up to date.* Contract K.40	**HSAG Required Evidence:** • Policies, procedures, and workflows **Evidence as Submitted by the MCO:** Element 9: Standard XIII - Health Information Systems Data Exchange draft Whole Document	☐ Met ☒ Not Met
MCO Description of Process: Molina Healthcare will submit provider network file to HHS following the state required layout and frequency.		
HSAG Findings: The MCO provided the testing plan with HHS for the exchange of the Master Provider File and indicated that testing was successful for loading the provider data to the MCO's systems. However, it was not clear whether the MCO has not yet received the Waiver Provider and Services File from HHS or conducted testing to ensure the appropriate exchange and loading of this provider data.		
Required Actions: In order to receive a *Met* score, the MCO must provide confirmation that Molina is prepared to receive the Waiver Provider and Services File from HHS and will follow a similar testing process for the exchange and loading of this information.		
Plan to Remedy Deficiency: Molina Healthcare of Iowa successfully tested this file on February 27, 2023, during the first cycle of testing with HHS. We are prepared to receive the Production Provider Waiver and Services File from HHS on June 1, 2023. We have uploaded to SAFE "HHS Email RE_Molina Test Files Sent".		
Individual(s) Responsible: Michael Wharton and Jeff Cangialosi		
Completion Date: 6/1/23		

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Feedback: The MCO's remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Appendix F. Financial Management Data Files

Financial Readiness Tool—Requested Files
Annual NAIC Financial Statement
Printed Investment Schedule
Quarterly Financial Statement
Credit Insurance Experience Exhibit
Accident & Health Policy Experience Exhibit
Actuarial Opinion on Reserve Adequacy
Actuarial Certification of Reserve Adequacy
Independent Audit of Reserve Adequacy
Executive Summary of the PBR Actuarial Report
Variable Annuities Statement of the PBR Actuarial Report
RAAIS required by Valuation Manual
Reasonableness & Consistency of Assumptions Certificate (required by Actuarial Guideline XXXV)
Reasonableness of Assumptions Certification (required by Actuarial Guideline XXXV)
Reasonableness of Assumptions Certification (required by Actuarial Guideline XXXVI—Update Market Value)
Reasonableness & Consistency of Assumptions Certificate (required by Actuarial Guideline XXXVI—Updated Market Value)
Reasonableness of Assumptions Certification for Implied Guaranteed Rate Method (required by Actuarial Guideline XXXVI)
RBC Certification
Statement on Non-Guaranteed Elements
PBR Actuarial Report
Life, Health & Annuity Guaranty Assessment Base Reconciliation Exhibit
Life, Health & Annuity Guaranty Assessment Base Reconciliation Exhibit Adjustment Form

Financial Readiness Tool—Requested Files
Management Discussion & Analysis
Risk-Based Capital Report
Supplemental Health Care Exhibits
Supplemental Health Care Exhibit's Allocation Report
Supplemental Schedule O
Supplemental Investment Risk Interrogatories
VM-20 Reserves Supplement
Variable Annuities Statement
Trusteed Surplus Statement
Workers' Compensation Carve-Out Supplement
Accountants Letter of Qualifications
Audited Financial Reports
Audited Financial Reports Exemption Affidavit
Management's Report of Internal Control Over Financial Reporting
Notification of Adverse Financial Condition
Corporate Governance Annual Disclosure
Form F—Enterprise Risk Report
Own Risk and Solvency Assessment (ORSA)

Financial Readiness Tool—Audited Financial Report	
1. Assess compliance with Audited Financial Report requirements. Were the financial statements included in the Audited Financial Report:	
Required	*Comments*
a. Based on statutory accounting practices?	Yes
b. Specific to the insurer rather than on a consolidated or combined basis?	Yes
2. Assess the details of the Audited Financial Report and identify risks.	
Required	*Comments*
a. What type of opinion was issued by the certified public accountant (CPA)? • Unmodified • Modified • Qualified • Adverse • Disclaimer of opinion	Unmodified
b. If the opinion was modified, which type of opinion was issued and what was the reason for the deviation?	N/A
c. Were any differences noted between information included in the Audited Financial Report and the insurer's Annual Financial Statement? • Total Assets • Net Income • Surplus	No

Financial Readiness Tool—Statement of Actuarial Opinion (SAO)	
1. Determine if the following were included in the SAO or otherwise provided.	
Required	*Comments*
a. Does the SAO include a completed Table of Key Indicators?	Reviewed WA version - Yes
b. Does the SAO state the actuary's qualifications and affiliation?	Yes
c. Was the actuary appointed by the board of directors (or its equivalent) or by a committee of the board by December 31 of the calendar year for which the SAO was rendered?	Yes
d. Is this the same actuary who was appointed for the previous SAO?	Yes
i. If "no", did the health entity notify the domiciliary state insurance regulator within 5 business days of the replacement? (When reviewing compliance with Section 1, note that the publication of the changes to the Health SAO Annual Statement Instructions in September 2009 may impact the timeliness of notification and compliance.)	N/A
ii. Within 10 business days of the above notification, did the health entity also provide an additional letter stating whether or not there were any disagreements with the former actuary during the preceding 24 months and also in writing requested the former actuary provide a letter of agreement?	
iii. Did the company provide the responsive letter from the replaced actuary?	
e. Do the reserve amounts included in the SAO agree with the amounts per the Annual Financial Statement?	Yes
f. If the Appointed Actuary has not examined the underlying records and has relied upon the data prepared by the health entity or a third party, is there a certification letter attached to the SAO signed by the individual or firm who prepared such underlying data?	N/A
2. Determine if the following were included in the SAO regarding source data and prescribed items.	
Required	*Comments*
a. The Health Annual Statement Instructions list A through H as prescribed items. If the following items are included in the Annual Financial Statement and required by the Annual Statement Instructions, does the SAO cover the following in the scope and opinion of amounts. Per Annual Statement Instruction: A. Claims unpaid (Page 3, Line 1); B. Accrued medical incentive pool and bonus payments (Page 3, Line 2);	All included

Financial Readiness Tool—Statement of Actuarial Opinion (SAO)	
C. Unpaid claims adjustment expenses (Page 3, Line 3); D. Aggregate health policy reserves (Page 3, Line 4) including unearned premium reserves, premium deficiency reserves, and additional policy reserves from the Underwriting and Investment Exhibit – Part 2D; E. Aggregate life policy reserves (Page 3, Line 5); F. Property/casualty unearned premium reserves (Page 3, Line 6); G. Aggregate health claim reserves (Page 3, Line 7); H. Any other loss reserves, actuarial liabilities, or related items presented as liabilities in the annual statement; I. Specified actuarial items presented as assets in the annual statement.	
b. Any examples of an item included in H above include the retrospective premium asset (Page 2, line 15.3). If any of the above are "no," identify item(s) that are missing.	N/A
3. Does the SAO state the following:	
Required	*Comments*
a. Does the SAO state: "In my opinion, the amounts carried in the balance sheet on account of the items identified above":	All Included
i. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles?	
ii. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared?	
iii. Meet the requirements of the insurance laws and regulations of the state of domicile, and are at least as great as the minimum aggregate amounts required by any state in which this statement is filed or are at least as great as the minimum aggregate amounts required by any state with the exception of the following states. For each listed state a separate SAO was submitted to that state that complies with the requirements of that state?	
iv. Make good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements.	
v. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Statement of the preceding year-end?	
vi. Include appropriate provisions for all actuarial items that ought to be established.	

Financial Readiness Tool—Statement of Actuarial Opinion (SAO)	
b. The Annual Financial Statement, Underwriting and Investment Exhibit – Part 2B was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice.	
c. Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this SAO.	

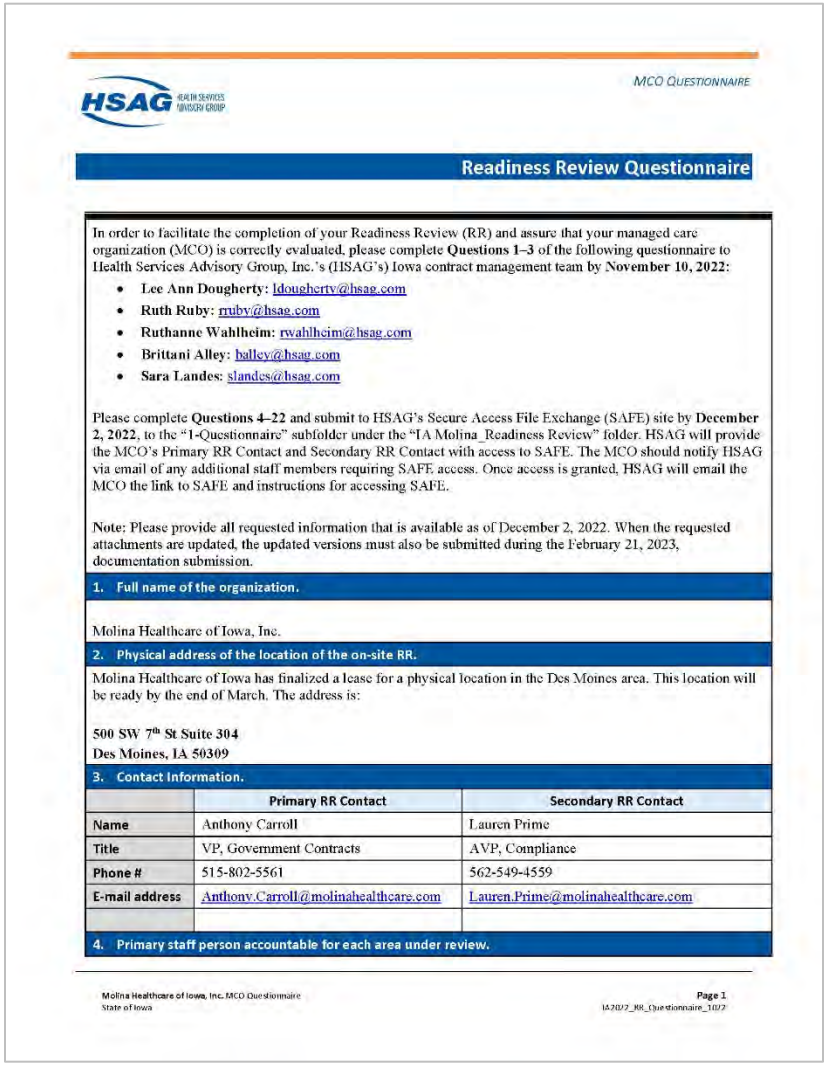
Financial Readiness Tool—Reserve Adequacy and Valuation		
1. Review the results of the Actuarial Opinion Assessment.		
Required	*Comments*	
a. Review the results of the Statement of Actuarial Opinion Worksheet. Were any concerns noted regarding the valuation of the insurer's reserves in accordance with minimum statutory valuation standards?	No	
2. Review reserve development to assess if reserves are adequate.		
Required	*Benchmark*	*Result*
a. Compare the one-year reserve development to capital and surplus and review and explain any adverse loss development results. [Annual Financial Statement, Underwriting and Investment Exhibit – Part 2B]	>10% or < -10%	No
i. Did the insurer report a reserve deficiency that is greater than 5% of capital and surplus?		
ii. Has there been an increase or decrease in the claim reserve and claim liability as a percentage of incurred claims since prior year-end?		
Required	*Comments*	
b. Review the Annual Financial Statement, Underwriting and Investment Exhibit – Part 2C. Has there been an adverse trend or unusual fluctuation over the last five years?	No	
c. Review the Annual Financial Statement, Underwriting and Investment Exhibit – Part 2B and Part 2C. Has the reserve been adequate to pay actual claims?	N/A	
d. Review the Annual Financial Statement, Underwriting and Investment Exhibit to determine which lines of business may have been under reserved at the prior year-end.	N/A	
e. If significant concerns regarding reserve development are identified, request the assistance of a department or consulting actuary in reviewing and assessing the adequacy of the reserves carried by the insurer.	N/A	
3. Assess loss ratios and underwriting losses as indicators of reserve adequacy.		
Required	*Benchmark*	*Result*
a. Underwriting loss by line of business	<0	None
b. Change in the loss ratio for any product line from the prior year	>10 pts or <-10 pts	N/A

Financial Readiness Tool—Reserve Adequacy and Valuation		
Required	*Comments*	
c. Compare the direction of any changes in the loss ratio to the direction of changes in membership. Is there an indication that increased loss ratios may be resulting from falling membership?	No	
d. Review the ratio of claims unpaid plus aggregate health reserve to incurred claims by line of business for past years to determine unusual fluctuations or trends between years.	N/A	
4. Assess unpaid claims adjustment expenses.		
Required	*Benchmark*	*Result*
a. Ratio of unpaid claims adjustment expenses to claims unpaid	>10%	0.00%
b. Ratio of unpaid claims adjustment expenses to incurred claims adjustment expenses	>20%	0.00%
5. Review other information available or requested to assess reserve valuation and adequacy.		
Required	*Comments*	
a. Review the insurer's description of the valuation standards used in calculating the additional contract reserves (which is required to be attached to and filed with the Annual Financial Statement) and consider whether the reserve bases, interest rates, and/or methods appear reasonable.	Reviewed WA Sample	

Financial Readiness Tool—Cash Flow From Operations		
1. Review cash flow from operations and determine if any concerns exist.		
Required	*NAIC Benchmark*	*Result*
a. Net cash from operations to capital and surplus.	<-5%	2%
b. Prior year net cash from operations to capital and surplus.	<-5%	3%
Own Risk and Solvency Assessment (ORSA) Summary Report:	*Comments*	
If the insurer is required to file an ORSA or is part of a group that is required to file ORSA: • Did the ORSA Summary Report analysis conducted by the lead state indicate any reserving risks that require further monitoring or follow-up?	No	
• Did the ORSA Summary Report analysis conducted by the lead state indicate any mitigating strategies for existing or prospective reserving risks?	N/A	

Financial Readiness Tool—Cash Flow From Operations	
Holding Company Analysis:	*Comments*
• Did the Holding Company analysis conducted by the lead state indicate any reserving risks impacting the insurer that require further monitoring or follow-up?	No
• Did the Holding Company analysis conducted by the lead state indicate any mitigating strategies for existing or prospective reserving risks impacting the insurer?	N/A

Appendix G. MCO Readiness Review Questionnaire



MCO QUESTIONNAIRE

Readiness Review Questionnaire

In order to facilitate the completion of your Readiness Review (RR) and assure that your managed care organization (MCO) is correctly evaluated, please complete **Questions 1–3** of the following questionnaire to Health Services Advisory Group, Inc.'s (HSAG's) Iowa contract management team by **November 10, 2022**:

- **Lee Ann Dougherty:** ldougherty@hsag.com
- **Ruth Ruby:** rruby@hsag.com
- **Ruthanne Wahlheim:** rwahlheim@hsag.com
- **Brittani Alley:** balley@hsag.com
- **Sara Landes:** slandes@hsag.com

Please complete **Questions 4–22** and submit to HSAG's Secure Access File Exchange (SAFE) site by **December 2, 2022**, to the "1-Questionnaire" subfolder under the "IA Molina_Readiness Review" folder. HSAG will provide the MCO's Primary RR Contact and Secondary RR Contact with access to SAFE. The MCO should notify HSAG via email of any additional staff members requiring SAFE access. Once access is granted, HSAG will email the MCO the link to SAFE and instructions for accessing SAFE.

Note: Please provide all requested information that is available as of December 2, 2022. When the requested attachments are updated, the updated versions must also be submitted during the February 21, 2023, documentation submission.

1. Full name of the organization.

Molina Healthcare of Iowa, Inc.

2. Physical address of the location of the on-site RR.

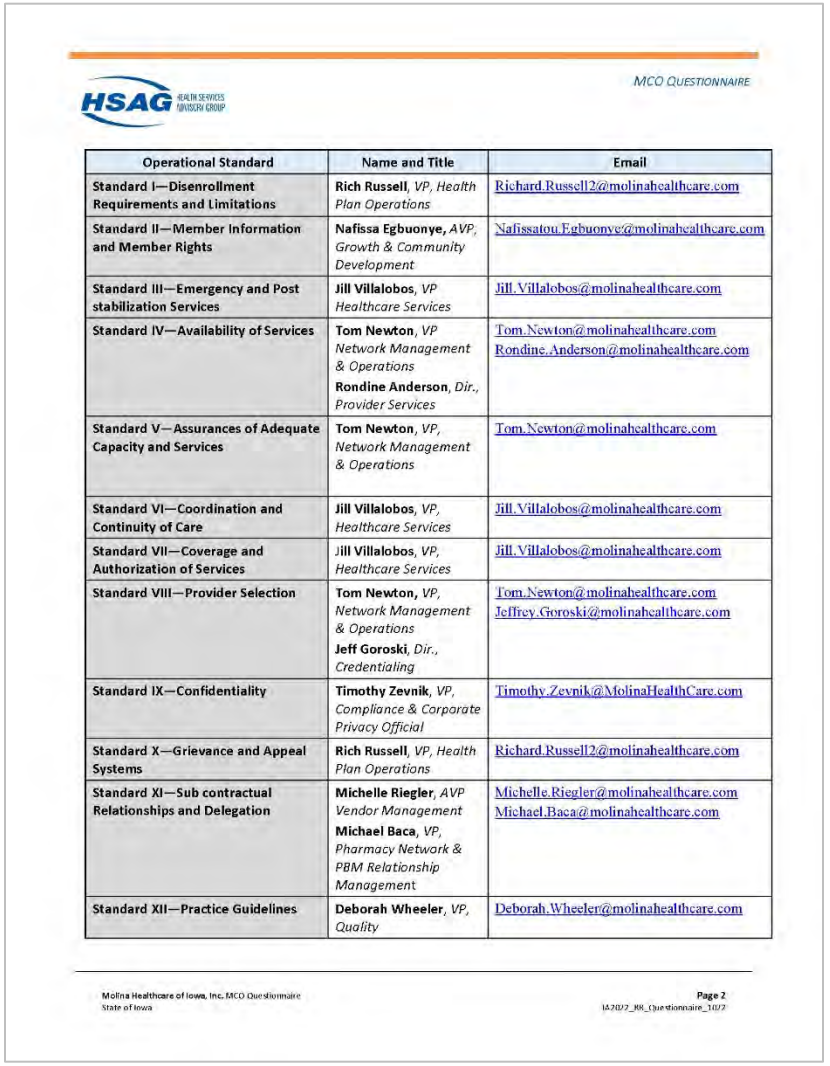
Molina Healthcare of Iowa has finalized a lease for a physical location in the Des Moines area. This location will be ready by the end of March. The address is:

500 SW 7th St Suite 304
Des Moines, IA 50309

3. Contact Information.

	Primary RR Contact	Secondary RR Contact
Name	Anthony Carroll	Lauren Prime
Title	VP, Government Contracts	AVP, Compliance
Phone #	515-802-5561	562-549-4559
E-mail address	Anthony.Carroll@molinahealthcare.com	Lauren.Prime@molinahealthcare.com

4. Primary staff person accountable for each area under review.



MCO QUESTIONNAIRE

Operational Standard	Name and Title	Email
Standard I—Disenrollment Requirements and Limitations	**Rich Russell**, *VP, Health Plan Operations*	Richard.Russell2@molinahealthcare.com
Standard II—Member Information and Member Rights	**Nafissa Egbuonye,** *AVP, Growth & Community Development*	Nafissatou.Egbuonye@molinahealthcare.com
Standard III—Emergency and Post stabilization Services	**Jill Villalobos**, *VP Healthcare Services*	Jill.Villalobos@molinahealthcare.com
Standard IV—Availability of Services	**Tom Newton**, *VP Network Management & Operations* **Rondine Anderson**, *Dir., Provider Services*	Tom.Newton@molinahealthcare.com Rondine.Anderson@molinahealthcare.com
Standard V—Assurances of Adequate Capacity and Services	**Tom Newton**, *VP, Network Management & Operations*	Tom.Newton@molinahealthcare.com
Standard VI—Coordination and Continuity of Care	**Jill Villalobos**, *VP, Healthcare Services*	Jill.Villalobos@molinahealthcare.com
Standard VII—Coverage and Authorization of Services	**Jill Villalobos**, *VP, Healthcare Services*	Jill.Villalobos@molinahealthcare.com
Standard VIII—Provider Selection	**Tom Newton,** *VP, Network Management & Operations* **Jeff Goroski**, *Dir., Credentialing*	Tom.Newton@molinahealthcare.com Jeffrey.Goroski@molinahealthcare.com
Standard IX—Confidentiality	**Timothy Zevnik**, *VP, Compliance & Corporate Privacy Official*	Timothy.Zevnik@MolinaHealthCare.com
Standard X—Grievance and Appeal Systems	**Rich Russell**, *VP, Health Plan Operations*	Richard.Russell2@molinahealthcare.com
Standard XI—Sub contractual Relationships and Delegation	**Michelle Riegler**, *AVP Vendor Management* **Michael Baca**, *VP, Pharmacy Network & PBM Relationship Management*	Michelle.Riegler@molinahealthcare.com Michael.Baca@molinahealthcare.com
Standard XII—Practice Guidelines	**Deborah Wheeler**, *VP, Quality*	Deborah.Wheeler@molinahealthcare.com

Standard XIII—Health Information Systems	This program area will be assessed through the Information Systems Review. Please see below.	
Standard XIV—Quality Assessment and Performance Improvement Program	**Deborah Wheeler**, *VP, Quality*	Deborah.Wheeler@molinahealthcare.com
Standard XV—Program Integrity	**Scott Campbell**, *VP, Payment Integrity Fraud, Waste, and Abuse Programs*	Scott.Campbell@molinahealthcare.com
Information Systems Review	**Name and Title**	**Email**
Standard XIII—Health Information Systems	**Jeff Cangialosi**, *AVP IT Growth and Strategy* **Alison Hewitt**, *Program Director, PMO* **Timothy Zevnik**, *VP, Compliance & Corporate Privacy Official*	Jeffrey.Cangialosi@molinahealthcare.com Alison.Hewitt@molinahealthcare.com Timothy.Zevnik@MolinaHealthCare.com
Enrollment System	**Erica Tims-Sewell**, *Program Manager*	Erica.Tims-Sewell@molinahealthcare.com
Claims System	**Frank Vernaza**, *Dir., Claims*	Frank.Vernaza@molinahealthcare.com
Encounters System	**Doreen Welsch**, *Dir., Encounters*	Doreen.Welsch@molinahealthcare.com
Financial Management	**Name and Title**	**Email**
Financial Reporting and Monitoring	**Joan Noddings**, Iowa *CFO*	Joan.Noddings@molinahealthcare.com
Financial Solvency	**Joan Noddings**, Iowa *CFO*	Joan.Noddings@molinahealthcare.com

Questions 5-10: Please ensure all attachments include all requested documentation (e.g., when a question references a contract section, refer to that section to ensure all contract provisions are addressed). When the MCO is submitting attachments to support responses to this questionnaire, please save all documents using the19\ naming convention specified in each section.

5. **Submit evidence that the MCO is licensed and in good standing in the State of Iowa as a health maintenance organization (HMO) in accordance with the Iowa Administrative Code (IAC) Chapter 191-40 and Contract A.02.**

   Naming convention: RRQ_Attachment 5_Licensure

6. **Submit the MCO's implementation plan for the Iowa Medicaid, Iowa Health and Wellness Plan, and Hawki programs. The implementation plan must:**

   a. **Comply with Contract A.21.**
   b. **Include the MCO's plan to submit all written materials to HHS timely (e.g., policies and procedures, marketing materials, member handbook, provider manual) as required in accordance with MED-24-005. The plan must include the name of the document, the required timeframe for submission to HHS, the date submitted to HHS, and the date approved by HHS.**

   Naming convention: RRQ_Attachment 6_Implementation Plan
   Naming convention: RRQ_Attachment 6_HHS Document Approval Plan

7. **Submit an organizational chart showing the functional linkage of all major operational areas specified in Contract A.03. The organizational chart must:**
   a. **Include the percentage of all work in each functional area performed locally in Iowa in accordance with Contract A.14.**

   Naming convention: RRQ_Attachment 7_Org Chart Operational Areas

8. **Submit the MCO's operational staffing plan[1]. The operational staffing plan must:**
   a. **Include the requirements of Contract A.05-A.07.**
   b. **Include how the MCO assessed the need for staffing and resources to accommodate the membership for Iowa Medicaid, Iowa Health and Wellness Plan, and Hawki programs.**
   c. **Include recruitment strategies for staffing and resources.**
   d. **Include the number of fulltime equivalent (FTE) positions, and how many are filled/vacant.**
   e. **Include the percentage of local staff in each functional area who have been onboarded in accordance with Contract A.11.**
   f. **Include how the MCO will evaluate the sufficiency of staffing and resources after July 1, 2023.**

   Naming convention: RRQ_Attachment 8_Staffing Plan

9. **Submit the MCO's training plan[2] for staff responsible for Iowa Medicaid, Iowa Health and Wellness Plan, and Hawki programs. The training program must:**
   a. **Comply with Contract A.13.**
   b. **Include all major operational areas specified in Contract A.03.**

   Naming convention: RRQ_Attachment 9_Training Plan

[1] The operational staff plan must be a living document and be updated on an ongoing basis. The MCO must be prepared to submit the operational staff plan periodically (and as requested by HSAG) during the readiness review process.
[2] The staff training plan must be a living document and be updated on an ongoing basis. The MCO must be prepared to submit the staff training plan periodically (and as requested by HSAG) during the readiness review process.

10. Submit the MCO's provider network onboarding plan[3] demonstrating it has the capacity to serve the expected enrollment for Iowa Medicaid, Iowa Health and Wellness, and Hawki programs. The provider network onboarding plan must:

- **a. Include how the MCO assessed the need for number/mix of provider types.**
- **b. Include the number/mix of provider types expected to be contracted with the MCO by July 1, 2023, and the number/mix of provider types currently contracted with the MCO.**
- **c. Include an analysis of time/distance standards in accordance with Exhibit C: General Access Standards (when assignment of membership occurs in April 2023).**
- **d. Include how the MCO will monitor the sufficiency of its provider network capacity after July 1, 2023.**
- **e. Include a contingency plan for ensuring access and continuity of care in the event of a gap in the MCO's provider network.**

Naming convention: RRQ_Attachment 10_Provider Network Onboarding Plan

Questions 11-22: Provide a high-level narrative description in the space provided below for each program area. Please ensure all requested information is included. When responding, the MCO should not refer to MCO policies or procedures and/or include federal or state contract language, but instead provide a description of the internal operational processes to support the federal or state contract requirements. When the MCO is submitting attachments to support responses to this questionnaire, please save all documents using the naming convention specified in each section.

11. Describe the enrollment/disenrollment structure, and include:

- **a. Organizational chart of enrollment/disenrollment staff.**
  - **Naming convention: RRQ_Attachment 11_Enroll-Disenroll Org Chart**
- **b. Describe the delineation of responsibilities between corporate staff and state-level staff.**
- **c. System(s) used to maintain enrollment and disenrollment information.**
- **d. Provide a high-level overview of the enrollment/disenrollment processes.**

a. RRQ_Attachment 11_Enroll-Disenroll Org Chart

b. Molina's Corporate staff provides the infrastructure, resources, and services to Molina's Health Plans for our back-office functions, including enrollment, claims, member services, grievances and appeals, and delegation oversight. Our staffing plan includes a mix of Corporate and Health Plan employees, with most staff based locally in Iowa. Molina is a fully remote health plan meaning nearly all staff work from home. The staff listed as "Iowa" means that the staff will be residents of Iowa but will work remote from their homes. This model and depth of resources provides a contingency model should we experience a temporary gap in staffing.

[3] The provider network onboarding plan must be a living document and be updated on an ongoing basis. The MCO must be prepared to submit the provider network onboarding plan periodically (and as requested by HSAG) during the readiness review process.

Additionally, we will leverage this existing infrastructure, processes, and resources while we ramp up our local staffing.

c.

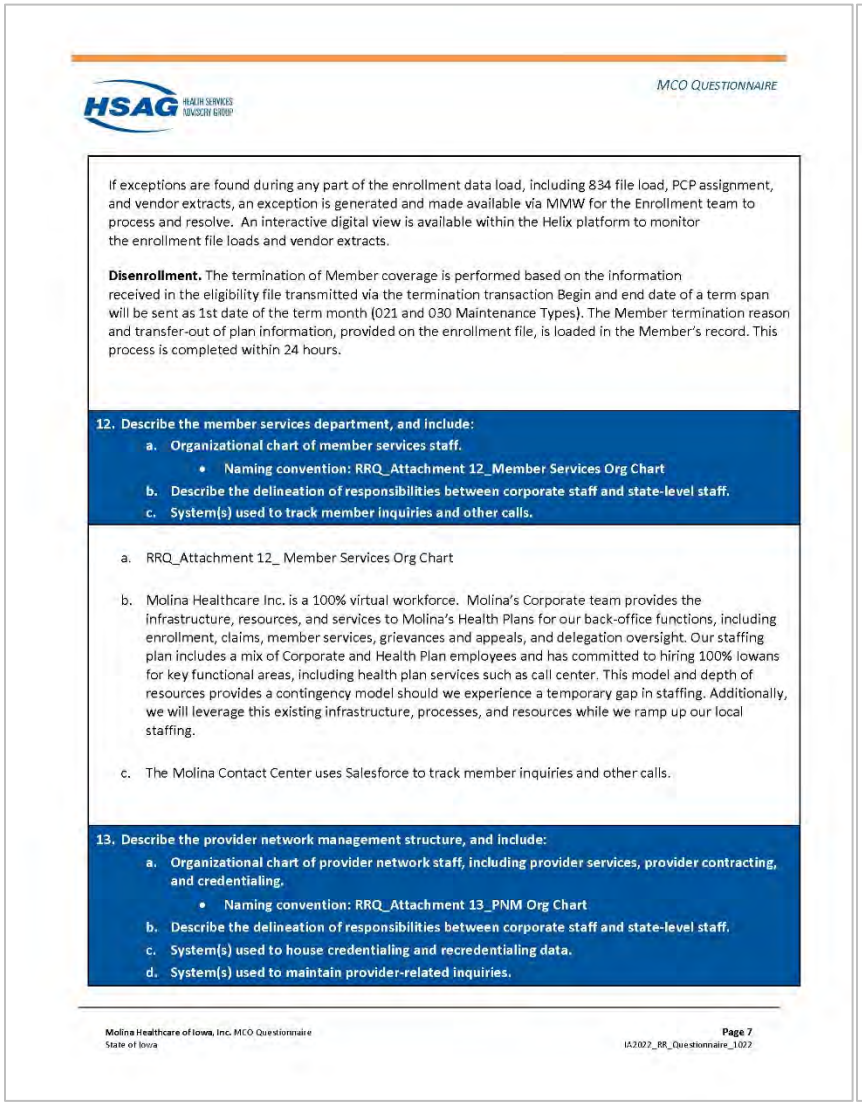
Key System	Description and Core Functionality	Iowa Functional Areas Served
MEG (Molina Eligibility Gateway)	Molina Eligibility Gateway (MEG) is an internal system built on Microsoft BizTalk and .NET technologies that serves as our streamlined eligibility, enrollment, and disenrollment management and data exchange platform. MEG is automated end-to-end eligibility inbound processes, decreasing processing time and improving overall performance.	Member Eligibility, enrollment, and disenrollment management

d. **Enrollment.** Our enrollment process begins upon receipt of daily or monthly enrollment files from Iowa HHS. Our Eligibility Validation Engine processes the file through initial validation procedures that confirm file layout, record counts, and HIPAA compliance. Once validated, the information is processed within 24 hours and then stored in the MEG database. The file is reconciled against internal Member information and, if a difference is found, the Member record is updated appropriately to match Iowa HHS information. Once the record is updated, a new ID card is issued to the Member if any critical information has changed that affects the card (for example, name, PCP).

The following process ensures enrollment data loads accurately into our core system, QNXT:

- **Enrollment Record on Eligibility File but not In Our Systems.** This interactive dashboard compares monthly full/audit eligibility file information against our system. Discrepancies are produced for review by our enrollment team; updates are entered to ensure accurate Coverage.
- **Enrollment Record in our Systems but Not on Eligibility File.** This interactive dashboard compares eligibility to enrollment files. If our system houses coverage not found on the full/audit file, we validate coverage for the Member and send discrepancies to Iowa HHS as Required.
- **Other Comparison Reports.** These interactive dashboards compare daily eligibility files against full/audit files to identify discrepancies to generate reports back to State regulators.
- **Enrollment/Eligibility Data**. We securely transmit data to our subcontractors upon receipt and loading of the files. Provider rosters are available through our Provider portal.

HIPAA 834 monthly enrollment files are full replacement files and show current status for each Member. Our process reads each record and validates the information currently in our system. If a change is found, the system is updated with the new information. Daily eligibility files contain new, changed, and terminated Members, whose information we load into QNXT before the next business day. As part of our standard process, we reconcile the data on each file with what is loaded in our eligibility and enrollment system, check for duplication, and discrepancies are sent to Molina Member Workflow (MMW) for our Enrollment team's review.



If exceptions are found during any part of the enrollment data load, including 834 file load, PCP assignment, and vendor extracts, an exception is generated and made available via MMW for the Enrollment team to process and resolve. An interactive digital view is available within the Helix platform to monitor the enrollment file loads and vendor extracts.

Disenrollment. The termination of Member coverage is performed based on the information received in the eligibility file transmitted via the termination transaction Begin and end date of a term span will be sent as 1st date of the term month (021 and 030 Maintenance Types). The Member termination reason and transfer-out of plan information, provided on the enrollment file, is loaded in the Member's record. This process is completed within 24 hours.

12. Describe the member services department, and include:

- **a. Organizational chart of member services staff.**
  - **Naming convention: RRQ_Attachment 12_Member Services Org Chart**
- **b. Describe the delineation of responsibilities between corporate staff and state-level staff.**
- **c. System(s) used to track member inquiries and other calls.**

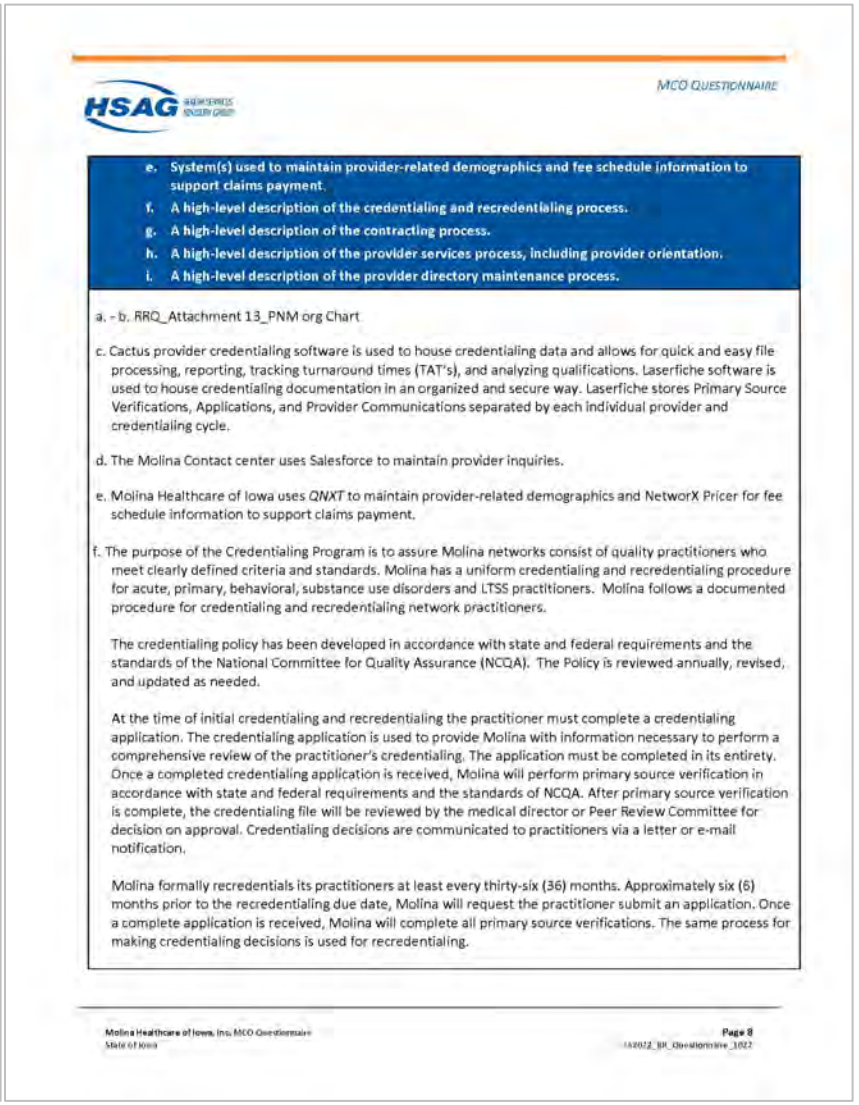
a. RRQ_Attachment 12_ Member Services Org Chart

b. Molina Healthcare Inc. is a 100% virtual workforce. Molina's Corporate team provides the infrastructure, resources, and services to Molina's Health Plans for our back-office functions, including enrollment, claims, member services, grievances and appeals, and delegation oversight. Our staffing plan includes a mix of Corporate and Health Plan employees and has committed to hiring 100% Iowans for key functional areas, including health plan services such as call center. This model and depth of resources provides a contingency model should we experience a temporary gap in staffing. Additionally, we will leverage this existing infrastructure, processes, and resources while we ramp up our local staffing.

c. The Molina Contact Center uses Salesforce to track member inquiries and other calls.

13. Describe the provider network management structure, and include:

- **a. Organizational chart of provider network staff, including provider services, provider contracting, and credentialing.**
  - **Naming convention: RRQ_Attachment 13_PNM Org Chart**
- **b. Describe the delineation of responsibilities between corporate staff and state-level staff.**
- **c. System(s) used to house credentialing and recredentialing data.**
- **d. System(s) used to maintain provider-related inquiries.**



- **e. System(s) used to maintain provider-related demographics and fee schedule information to support claims payment.**
- **f. A high-level description of the credentialing and recredentialing process.**
- **g. A high-level description of the contracting process.**
- **h. A high-level description of the provider services process, including provider orientation.**
- **i. A high-level description of the provider directory maintenance process.**

a. - b. RRQ_Attachment 13_PNM org Chart

c. Cactus provider credentialing software is used to house credentialing data and allows for quick and easy file processing, reporting, tracking turnaround times (TAT's), and analyzing qualifications. Laserfiche software is used to house credentialing documentation in an organized and secure way. Laserfiche stores Primary Source Verifications, Applications, and Provider Communications separated by each individual provider and credentialing cycle.

d. The Molina Contact center uses Salesforce to maintain provider inquiries.

e. Molina Healthcare of Iowa uses *QNXT* to maintain provider-related demographics and NetworX Pricer for fee schedule information to support claims payment.

f. The purpose of the Credentialing Program is to assure Molina networks consist of quality practitioners who meet clearly defined criteria and standards. Molina has a uniform credentialing and recredentialing procedure for acute, primary, behavioral, substance use disorders and LTSS practitioners. Molina follows a documented procedure for credentialing and recredentialing network practitioners.

The credentialing policy has been developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Policy is reviewed annually, revised, and updated as needed.

At the time of initial credentialing and recredentialing the practitioner must complete a credentialing application. The credentialing application is used to provide Molina with information necessary to perform a comprehensive review of the practitioner's credentialing. The application must be completed in its entirety. Once a completed credentialing application is received, Molina will perform primary source verification in accordance with state and federal requirements and the standards of NCQA. After primary source verification is complete, the credentialing file will be reviewed by the medical director or Peer Review Committee for decision on approval. Credentialing decisions are communicated to practitioners via a letter or e-mail notification.

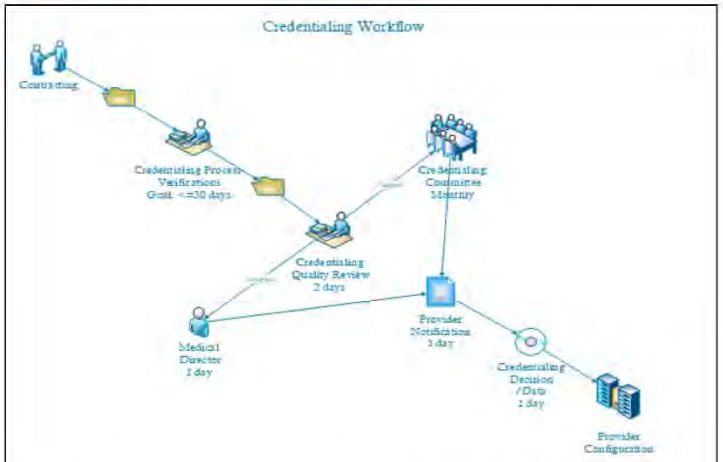
Molina formally recredentials its practitioners at least every thirty-six (36) months. Approximately six (6) months prior to the recredentialing due date, Molina will request the practitioner submit an application. Once a complete application is received, Molina will complete all primary source verifications. The same process for making credentialing decisions is used for recredentialing.

g. A Provider, identified through a network gap and/or any willing provider, receives a contract packet via email, US mail, or fax depending on the need. The contract packet consists of a letter introducing Molina Healthcare of Iowa, Inc. including specific thorough instructions as to how to fill out each document. The packet includes the following:

- Molina Story Flyer
- Company Fact Sheet
- HDO Credentialing Application
- Ownership and Disclosure Form
- Credentialing Practitioner Form
- Hospital, Provider, or Ancillary Provider Services Agreement (as applicable to the Provider Type)
- Client Service Area Form (counties served)
- Provider Roster Template
- Sample CMS-1500 Form
- W-9
- Final Checklist – to ensure all forms filled out

Once the contract packet is received, the contract is scrubbed by the Contract Specialist to ensure all components are met eliminating any delays in the process. Once the contract is through the process below, a Welcome Packet is sent to the Provider containing the following information:

- A fully executed contract
- A dedicated Molina Provider ID for the Molina Provider Portal
- Notification that a Provider Services Representative will be in touch as soon as possible to conduct Provider Orientation session with applicable staff
- Dedicated Provider Services telephone number and email box for immediate questions
- Link to our Molina Website



h. Provider Services are champions for provider training and education, in alignment with Molina Healthcare's overall mission, core values, and strategic plan and in compliance with all relevant federal, state, and local regulations. Provider Services staff are the primary point of contact between Molina Healthcare and the contracted provider network. They are responsible for the provider training, network management and ensuring knowledge of and compliance with Molina healthcare policies and procedures while achieving the highest level of customer service.

The Director of Provider Services oversees and manages all functions of the department. Provider Services also works closely with Provider Contracts, Network Management, and Provider Engagement, in addition to collaborating with other health plan departments to ensure operational success for contracted network providers.

Provider Services at Molina Healthcare consists of the following roles:

- Sr. Rep, Provider Services
- Rep, Provider Services

Provider Services Representatives (PSR's) are required to have an in-depth knowledge of provider services and contracting subject matter expertise, have the capability to resolve complex provider issues, and serve as a subject matter expert for other departments.

Provider Services conducts regular provider site visits within assigned region/service area as needed to meet or exceed the Health Plan's monthly site visit goals. A key responsibility of the PSR during these visits is to proactively engage with the provider and staff to determine, for example, non-compliance with Molina

policies/procedures or CMS guidelines/regulations, or to assess the non-clinical quality of customer service provided to Molina members.

Provide on-the-spot training and education as needed, which may include counseling providers diplomatically, while retaining a positive working relationship.

Response Turn-Around-Time (TAT)

- Calls and emails must be acknowledged within 24-48 hours. If follow-up is needed after acknowledgement, Provider Reps set an expectation with the provider when additional follow-up can be expected.
- PSR's must use an Out of Office Reply when visiting providers in the field, or if out of the office using PTO.
- PSR's must also use a specific outgoing voicemail greeting and designate a partner (another team member) to assist their providers during absences when using PTO.

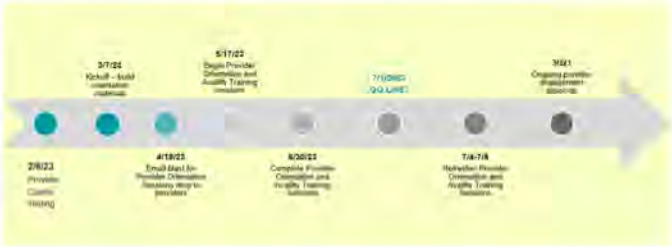
PSR's initiate, coordinate, and participate in problem-solving meetings between the provider and Molina stakeholders, including senior leadership and physicians. Such meetings would occur to discuss and resolve issues related to utilization management, pharmacy, quality of care, and correct coding, for example.

The main priority is to deliver effective training and presentations to assigned providers and their staff, while answering questions that come up on behalf of the health plan. As needed, they deliver training and presentations to larger groups, such as leaders and management of provider offices (including large multispecialty groups or health systems, executive level decision makers, Association meetings, and JOC's).

Please reference a copy of the "*Provider Engagement Timeline*" prior to go-live that breaks out the following initiatives as it relates to Provider Orientations:

- February 2023
  - Provider Claims Testing begins
- March/April 2023
  - Compile "provider training coming in May"' talking points for PSR's
  - Continue to build educational materials for Provider Orientation
  - Email/Fax blast announcing Provider Orientation Sessions
- May 2023
  - Orientations begin
  - Availity Provider Portal Training begin
  - Complete Provider Orientations by 6/30/2023
- July 2023 – GO LIVE - Ongoing Provider orientation and training schedule
  - 7/4/23 - Availity Provider Portal refresher session
  - 7/5/23 – Refresher Provider Orientation session
  - 7/10/23 – Begin provider check-in sessions
  - 1st 30 days: Weekly provider check-in sessions
- Bi-weekly check-in sessions after 1st 30 days dependent upon provider needs
- Molina will move to monthly check-in sessions as needed, dependent upon provider needs

Provider Engagement Timeline



i. Our processes ensure that inaccurate Provider information is not a barrier to Member PCP selection or care; we prioritize a comprehensive, intuitive, and fully accurate Provider directory. The information in the Molina Healthcare Provider Directory comes from various sources, including self-reported information from practitioners and facility providers. Molina Healthcare makes reasonable efforts to validate that the information displayed is up to date and accurate.

- **Gathering information.** A variety of sources used, including but not limited to:
  - A provider can fill out and send in a Provider Information Update Form
  - A provider can call or send a fax to Molina with their data
  - Molina Healthcare collects provider information during the contracting process
  - Molina Healthcare updates data when a provider is first credentialed or being re-credentialed
  - We use CAQH for quarterly attestations of Provider data and process quarterly rosters submitted by Providers to Molina
- **Updates during Contracting.** Once we load the Provider's contract information into Molina Administrative Platform (MAP) system, our core processing system, we update our online Provider directory within one business day. Our Provider Contracting team audits the information in MAP for newly contracted Providers within 30 days of the initial load.
- **Updates by Providers.** Our Provider portal displays a link to CAQH for providers to make demographic updates.
- **Updates through Members.** The Provider online directory allows Members to report Provider demographic changes. Molina's Provider Data Validation Team uses the information provided by Members to contact the Provider to ensure the change is valid before making the change to the Provider record and online directory, furthering our commitment to ensure provider data accuracy to improve the Member and Provider experience.

- **Continued Updates.** To ensure continued accuracy of Provider information, we automatically update Provider demographic information. This minimizes Provider burden while ensuring Members have access to up-to-date Provider information. We will bring the best practice of using an external Vendor to validate Provider directory data to ensure accuracy.

- **Paper Directory Updates.** Member Call Center or a Molina One-Stop Help Center staff can print on-demand from the online directory onsite, which is updated nightly. A full paper directory is validated for accuracy, produced monthly, and mailed, if requested.

14. Describe the care management structure, and include:

a. Organizational chart of care management staff.
- **Naming convention: RRQ_Attachment 14_CM Org Chart**

b. Names of key care management staff (directors, managers, supervisors, and number of FTEs).

c. Describe the delineation of responsibilities between corporate staff and state-level staff.

d. System(s) used to house care management data.

e. Provide a high-level process of identifying members for care management.

f. Provide a high-level process of the transition of care process (e.g., transfer of members from one MCO to another).

a. RRQ_Attachment 14_CM Org Chart

b.
- Jill Villalobos-VP, Healthcare Services
- Brian Marston-AVP, Health Plan Long Term Services & Support (LTSS)
- Jean McClurken-Director, Behavioral Health
- Nilani Downs-Director, Healthcare Services

We are currently hiring our manager and supervisor level leaders.

c. Services provided for HROB, HM and Outbound Call Center (low risk members) are provided by Molina Clinical Services, LLC on behalf of Molina Healthcare of Iowa.

CM policy and practice guidelines are reviewed and approved by the NQIC and the Molina Healthcare of Iowa QIC and adopted for use by the Molina Healthcare of Iowa HCS Committee annually. All policy and practice guidelines are reviewed for alignment and compliance with any state regulatory or NCQA requirements and adopted by Molina Healthcare of Iowa accordingly.

d. Molina Healthcare of Iowa uses:
- Clinical Care Advance (CCA) to document CM activities,
- PEGA LTSS houses FSLR assessment outcome and the service planning tool.
- PEGA LOCMS (level of care management system) houses all Level of Care (LOC) assessment dates.
- mCare is the tablet used in the field and the data is synchronized to CCA

e. As required by regulatory guidelines, members are stratified utilizing a health-based risk assessment/adjustment tool, when pre-enrollment utilization data is available. This system assigns a risk level based on regulatory standards outlined in acuity grid upon enrollment. This risk score delineates the individual members for the appropriate Healthcare Services (HCS) staff assignment for further outreach, assessments, and follow-up based on level of acuity and member preference and need.

After pre-enrollment stratification, if applicable, members are stratified utilizing outcomes of the initial Health Risk Assessment, functional assessments, and other available historical data. Members may be stratified on a continuous and ongoing basis utilizing predictive modeling software. Molina's predictive modeling tool provides a current snapshot of active Molina members as of the date the data inputs are pulled. The base product includes member demographic data, medical and pharmacy claims, and provider data. The solution also incorporates labs data, if available, into the risk models and member characteristics. Predictive modeling member lists are distributed to health plan leadership and case managers to engage members and begin the case management process.

Members may also be assessed for appropriate risk stratification by referrals from member self-referral, providers, community agencies, identification of change in health status and other Molina staff.

f. Molina Healthcare of Iowa ensures that all members receive COC for medical, behavioral health, Long-Term Services and Supports (LTSS), Durable Medical Equipment (DME), and pharmacy benefits with their existing services as appropriate per regulatory requirements. Molina Healthcare of Iowa ensures that new members maintain current services with their existing providers during the transition period. During this period, Molina Healthcare of Iowa contracts with the member's existing out of network provider or if the provider is not willing to accept the agreement, Molina Healthcare facilitates a safe transition to a network provider. If services cannot be provided by a contracted provider, Molina identifies and authorizes services outside of its provider network.

Molina Healthcare provides continued health care services in accordance with the agreement in the Evidence of Coverage (EOC)/plan contract for:
- New members who are currently under management of a non-contracted provider/facility for an active course of treatment and who are eligible for continuation of coverage.
- Existing members currently under management of a provider/facility when a contract with Molina Healthcare of Iowa ends or a provider who changed their provider group(s). Molina Healthcare of Iowa assists members with transitioning to another provider as appropriate based on member preference.
- New and existing members whose network providers are not located within a reasonable distance from their respective place of residence.
- New members who are taking non-formulary drugs or medications that require prior authorization.

COC is administered within all applicable benefit limits and requirements. All members are notified of their COC rights by the EOC.

Molina Healthcare of Iowa advises members and providers:

- Before receiving care not covered at an in-network level.
- If they have received care that would not otherwise be covered at an in-network level of services.

Members can request to transition to an in-network provider during an active course of treatment per regulatory requirements.

15. Describe the utilization management structure, and include:

- **a. Organizational chart of utilization management staff, including the credentials of each staff member.**
  - **Naming convention: RRQ_Attachment 15_UM Org Chart**
- **b. Describe the delineation of responsibilities between corporate staff and state-level staff.**
- **c. Clinical guidelines used to make authorization decisions.**
- **d. System(s) used to record and track service authorizations and denials.**
- **e. A high-level overview of the coverage/service authorizations review process, including the process for handling denials.**
- **f. A high-level overview of the emergency and post stabilization services processes.**

a. RRQ_Attachment 15_ UM Org Chart

b. **Utilization Management (UM) authorization**-Services provided for Advanced Imaging, Transplant, Disease Management and High-Risk OB Case Management are provided by Molina Clinical Services, LLC., on behalf of Molina Healthcare of Iowa. UM for all other services will be performed by Registered Nurses (RN) licensed in Iowa with oversight by our Iowa Medical Directors.

Criteria Guidelines and Policy- Molina Healthcare, Inc.'s Prior Authorization Governance, Clinical Policy, and P&T Committees evaluate trends with current prior authorization (PA) guidelines, new technology and scientific advances to provide guidelines for determining coverage criteria. UM policy and practice guidelines are reviewed and approved by the NQIC and the Molina Healthcare of Iowa QIC and adopted for use by the Molina Healthcare of Iowa HCS Committee annually. All policy and criteria guidelines are reviewed for alignment and compliance with any state regulatory requirements and adopted by Molina Healthcare of Iowa accordingly.

Molina Healthcare of Iowa uses nationally recognized clinical review criteria based on sound medical evidence for making decisions about medical necessity and appropriateness of services. The criteria sources used may include:

- Iowa State Regulations and Iowa State Specific Criteria Guideline Sets
- When applicable, delegated Third party criteria guidelines when reviewed and approved for UM use in compliance with Molina policies
- Corporate guidance documents and policies, including Molina Clinical Policy (MCP), Molina Clinical Review (MCR)
- Externally purchased, evidence-based decision-making criteria including InterQual® Criteria and MCG, American Society of Addition Medicine (ASAM)

- Criteria National Comprehensive Cancer Network (NCCN)
  - Level of evidence 2A or above me be considered for approval
- Hayes Technology Assessments
  - Hayes Rating of B or better for the treatment/device may be considered for approval
  - Hayes Rating of C or below does not have proven benefit or sufficient evidence, and would not be approved
- UpToDate
- Technology assessments established by nationally accepted governmental agencies, physician specialty societies, associations or academies and published in peer reviewed medical literature
- Well controlled studies published and referenced in medical or scientific literature with relevant clinical evidence supporting the assertion that the requested modality would provide benefit to the member and a clinical advantage over its competitors; two independent studies are preferred
- Specialty consultations by a third-party reviewer or Independent Review Organization (IRO)
- State-mandated long-term care assessment tools which determine eligibility and Molina time task protocols for authorization of LTSS to include waiver and state plan HCBS habilitation services.

d. Molina Healthcare of Iowa uses Pega UM to track and record service authorization and denials.

e. Requests for pre-service authorizations are built by non-clinical staff and reviewed for eligibility, benefit coverage, and provider status. Pre-service medical necessity review is then completed by clinical staff in compliance with established medical policy and benefit criteria.

If the request does not meet medical necessity criteria, the request is sent to a Medical Director or other appropriate health professional (e.g., Pharmacist, External Review). When appropriate, the Medical Director or other appropriate health professional will consult with the requesting provider. Health professionals make all denial decisions.

All adverse determinations will be communicated to the requesting practitioner and member based on Iowa regulatory requirements. Adverse determination notifications include the rationale for the determination in plain terms and cite the utilization criteria or benefit provisions used in making the determination. Denial letters also provide information about the members' appeal rights and the appeals process, how to obtain criteria used in the decision and the various levels of review that are available.

f. Prior authorization is not required for emergency stabilization services, which also includes emergency Behavioral Health (BH) care, urgent care, and BH crisis stabilization provided in an emergent setting. Providers may also provide post stabilization in observation level of care without authorization.
If the provider notifies Molina that they are requesting post stabilization services prior to admission, we will decide within 1 hour of receipt when the request is received

If the request meets medical necessity criteria, the request will be approved. If it does not meet medical necessity criteria, the treating physician will be given the opportunity to speak to a Molina Medical Director (MD) to determine the appropriate level of care for the members.

If, after discussion, the member remains in the hospital because the treating physician believes the member is unstable without the agreement of the Molina Healthcare Medical Director, the facility will be instructed that post stabilization services at an observation or emergency level of care do not require authorization and to contact Molina Healthcare if the member condition changes and reassessment of the level of care is needed.

In the event the treating physician wishes to continue care without prior authorization for admission, a post service claims review may also occur.

16. Describe the grievance structure, and include:

- **a. Organizational chart of staff processing grievances, including the credentials of each staff member.**
  - **Naming convention: RRQ_Attachment 16_Grievances Org Chart**
- **b. Describe the delineation of responsibilities between corporate staff and state-level staff.**
- **c. System(s) used to record and track grievances.**
- **d. Provide a high-level overview of the grievance resolution process.**

a. RRQ_Attachment 16_Grievances Org Chart

b. All Appeals & Grievance Staff (A&G) are dedicated to the investigation, resolution, and appropriate effectuation/notification of Iowa appeals & grievances. Based on the case type, the A&G staff collaborates with the various corporate operational teams to ensure a thorough and accurate investigation of the grievance. In addition, the corporate and state teams review key operational metrics, identified issues, trends and escalations through routine joint operating committees and workgroups.

c.

Key System	Description and Core Functionality	Iowa Functional Areas Served
Pega Appeals and Grievances Application	Pega is a modern, advanced, and fully unified application platform that provides clinical guidelines to inform medical and clinical care teams and supports grievances and appeals including associated care-related documents, improving outcomes through more effective UM.	• Grievances and Appeals • Referrals and prescriptions • Automatic service-level agreement management and notification • Reporting

d. A grievance can be received verbally or in writing through various channels within the organization (i.e., Contact Center, email, fax, mail, etc.). Immediately upon receipt of the grievance, it is input into the complaint tracking system (Pega) for acknowledgement and assignment to an A&G Specialist. The A&G Specialist will thoroughly investigate the grievance, in collaboration with other operational SME's, external vendors, etc. as needed to provide an accurate and complete resolution to the member. As expeditiously as possible, the A&G Specialist will provide the resolution verbally or in writing to the complainant. All

documentation related to the investigation and resolution of the grievance will be stored in the complaint tracking system, Pega.

17. Describe the appeals structure, and include:

- **a. Organizational chart of staff processing appeals, including the credentials of each staff member.**
  - **Naming convention: RRQ_Attachment 17_Appeals Org Chart**
- **b. Describe the delineation of responsibilities between corporate staff and state-level staff.**
- **c. System(s) used to record and track appeals.**
- **d. Provide a high-level overview of the appeals resolution process.**

a. RRQ_Attachment 17_Appeals Org Chart

b. All Appeals & Grievance Staff (A&G) are dedicated to the investigation, resolution, and appropriate effectuation/notification of Iowa appeals & grievances. Based on the case type, the A&G staff collaborates with the various corporate operational teams to ensure a thorough and accurate investigation of the appeal. In addition, the corporate and state teams review key operational metrics, identified issues, trends and escalations through routine joint operating committees and workgroups.

c.

Key System	Description and Core Functionality	Iowa Functional Areas Served
Pega Appeals and Grievances Application	Pega is a modern, advanced, and fully unified application platform that provides clinical guidelines to inform medical and clinical care teams and supports grievances and appeals including associated care-related documents, improving outcomes through more effective UM.	• Grievances and Appeals • Referrals and prescriptions • Automatic service-level agreement management and notification • Reporting

d. An appeal can be received verbally or in writing through various channels within the organization (i.e., Contact Center, email, fax, mail, etc.). Immediately upon receipt of the appeal, it is input into the complaint tracking system (Pega) for acknowledgement and assignment to an A&G Specialist. The A&G Specialist will thoroughly investigate the appeal, in collaboration with other operational SME's, external vendors, etc., as needed to provide an accurate and complete resolution to the members. If the case requires a clinical review, the case is routed to the Clinical Review Team for appropriate processing in collaboration with the Medicare Director, as needed. As expeditiously as possible, the A&G Specialist will provide the resolution verbally and in writing to the complainant. All documentation related to the investigation and resolution of the appeal will be stored in the complaint tracking system, Pega.

18. Describe the delegation oversight structure, and include:

- **a. Organizational chart of delegation oversight staff.**

- **Naming convention: RRQ_Attachment 18_Delegation Org Chart**

b. Describe the delineation of responsibilities between corporate staff and state-level staff.

c. Provide a description of the managed care contract obligations the MCO intends to delegate for the Iowa Medicaid, Iowa Health and Wellness, and Hawki programs.

d. Provide a high-level overview of the delegation oversight processes, including reporting expectations and monitoring activities (e.g., process for determining types of reports, frequency of reporting, and frequency of periodic formal reviews).

e. Provide a high-level description of the delegation oversight committee(s).

a. RRQ_Attachment 18_Delegation Org Chart

b. The Iowa Delegation Oversight team will have State-specific staff who will conduct monitoring and oversight of the IA delegated subcontractors. In addition, we ensure that additional parent company employees provide support in these activities. Subcontractor oversight activities will take place in coordinated fashion by Iowa-dedicated resources, with support from a Molina Healthcare team. Iowa's Delegation Oversight team will conduct scheduled and ad hoc auditing. The Molina Healthcare team will routinely generate performance dashboards and other monitoring reports. Jointly, these teams meet to evaluate, discuss, and take appropriate action on the subcontractor's demonstrated performance.

c. The largest subcontracting functions come through:

- Our parent company, Molina Healthcare – human resources, IT, legal, marketing, facilities, finance, call center overflow, medical policy, models of care and best practices, claims/encounters processing, healthcare services support, program integrity, subcontractor/delegation oversight.
- Caremark for PBM: claims processing, network management, rebate administration, pharmacy call center, and benefit and eligibility administration.
- MARCH® Vision Care for vision care services – call center, claims processing, credentialing
- Access2Care for non-emergency transportation – call center, claims processing, driver validation (credentialing).

Additionally, we will delegate credentialing to providers (e.g., MercyOne, Unity Point, University of Iowa) with demonstrated experience of an organized and established credentialing program.

d. Provide a high-level overview of the delegation oversight processes, including reporting expectations and monitoring activities (e.g., process for determining types of reports, frequency of reporting, and frequency of periodic formal reviews).

Our Iowa-based Compliance Officer, in conjunction with our Chief Executive Officer (CEO), directs our Delegation Oversight program. The Compliance Officer receives support from delegation management experts locally at the health plan (e.g., Sr. Auditor, Delegation Oversight) and across our organization, as well as the Delegation Oversight Committee, Compliance Committee, QM/QI Committee, and Joint Operating Committee(s), as applicable. This organizational structure ensures continuous Subcontractor support and monitoring.

We diligently help Subcontractors meet our high standards of performance excellence and, if needed, correct poor performance or nonperformance with corrective action plans (CAPs) and other contract enforcement options. To ensure high performance, we manage and oversee our Subcontractors through:

- **Key performance indicator dashboards.** Molina continuously monitors compliance using key performance indicator dashboards that help us manage compliance with Contract requirements. Using these dashboards and reports, we can identify any areas that are at risk, refocus efforts, and quickly escalate and resolve issues.

- **Reports.** We review daily, monthly, and quarterly reports outlining performance of delegated responsibilities, such as file exchanges and call center statistics, to ensure delivery, accuracy, and completeness of Subcontractor services. We use report data to confirm compliance with the State's metrics and key performance indicators and analyze data to identify emerging risks that are swiftly addressed, remediated, and/or mitigated.

- **Audits.** We conduct audits for functions delegated to each Subcontractor every year, or more frequently as requested. We also conduct ad hoc audits if we identify noncompliance or a trend in Member complaints. Our Delegation Oversight Committee reviews annual and ad hoc audit results and decides on appropriate courses of action, which may range from a CAP to termination, if necessary.

- **Meetings.** We use regularly scheduled internal meetings to assess Subcontractor performance against key performance indicators. We also conduct monthly and quarterly meetings, in many cases jointly with Subcontractor staff and stakeholders, to discuss performance and opportunities for improvement.

- **CAPs and other contract enforcement.** Our policies and procedures include guidelines for enforcement of nonperformance and corrective actions to improve performance. Subcontractors may be sanctioned, be required to pay penalties, or have their delegated functions revoked if performance is inadequate. In the event of significant underperformance, subcontracts may be terminated.

- **Regulatory/contractual change management.** The Delegation Oversight Committee communicates changes in regulations or health plan contracts through a formal, documented change management process, where details are provided to Subcontractors. Subcontractors affirm their understanding and related time frames needed to implement and execute changes. The Delegation Oversight Committee closely monitors Subcontractors throughout changes and conducts a post-implementation review and/or audit, depending on the complexity of the change.

e. Delegation Oversight Committee is the governing committee for delegation oversight program and its activities and reports up to the Quality Improvement Committee. The membership includes representation from MCO health plan leadership and from delegated functional areas including Credentialing, Contact Center, Claims and Quality and Compliance to ensure cross functional visibility. Meetings occur quarterly or more frequently to discuss significant compliance concerns. A typical quarterly meeting agenda will include review of annual audit results, any pre-assessment audits completed, status on open CAPs, and updates on Delegate performance against contractual requirements for the previous quarter. Delegation Oversight Policies and Procedures and the Program Description will be reviewed and approved annually.

19. Describe the health information system structure, and include:

- **a. Organizational chart of information systems staff.**
  - **Naming convention: RRQ_Attachment 19_HIS Org Chart**
- **b. Data flow chart demonstrating the interaction/integration of all information systems.**
  - **Naming convention: RRQ_Attachment 19_HIS Flow Chart**
- **c. Describe the delineation of responsibilities between corporate staff and state-level staff.**
- **d. System(s) used to maintain enrollment, claims, and encounter data.**
- **e. Provide a high-level overview of testing (internal and external) that has occurred, or is planned to occur prior to implementation, to ensure accuracy of enrollment, claims, and encounter data. Provide test plans as available.**

a. RRQ_ Attachment 19_HIS Org Chart

b. RRQ_ Attachment 19 _HIS Flow Chart

c. Corporate and state-level staff work in partnership to achieve all defined technical requirements. In general, the state-level staff are responsible for identifying and communicating requirements clearly including regulatory service level agreements (SLA) and responses to their corporate Information Technology (IT) partners for solution development and support. State-level staff are responsible for all day-to-day business operations and requirements, while corporate IT staff are responsible for technical solution build and support. The Molina Healthcare of Iowa health plan has an IT Business Relationship Manager who can assist with any required escalation along with solution ideation, enterprise technical standardization and technical consultation with regulatory and vendor partners.

d. System(s) used to maintain enrollment, claims, and encounter data.

Key System	Description and Core Functionality	Iowa Functional Areas Served
MAP	MAP is configured specifically to address government healthcare functions. As our core administrative solution and integration point for data exchange and transmission among all integrated MIS systems and applications, MAP provides flexibility of rules-based features and functions tailored specifically to IDHS requirements.	Member Enrollment and eligibility management, Provider Network management, Claims processing, Encounter submission, COB for claim with TPL, Reporting

Inbound Claims Platform	All claims from DHCFP's fiscal intermediary will go through Molina Edifecs + Qconnect platform, which will apply State-specific criteria. The tool screens Claims and sends them to MAP for adjudication. This system is compliant with all regulatory standards with proven scalability.	Claims processing edits, corrections, and adjustments
Edifecs Encounter Management (EM)	For IA Edifecs EM will be the core application that collects encounter data from all systems at a common gateway entry. AI-enabled coding automation with integrated submission compliance and analytics tools, breaks down encounter operations silos, and ensures compliance for encounter submissions.	Encounter submission

e. Testing configured benefits will take place as identified by the configuration team. This will entail:

- Reviewing and creating test cases based on BBRD's
- Execute test cases
- Report defects identified on master issue log and retest as needed
- Send to stakeholders for review and approval

End to End Testing/Integration testing will be utilized to validate the entire claim lifecycle from start to finish:

- Load/Add relevant member and claim data into QNXT
- Run Mass adjudication in QNXT
- Check run, payment, and EOB/EOP generation

Validate the Claims flow to ODS/Encounters and outbound extracts.

20. Describe the quality assessment and performance improvement (QAPI) structure, and include:

- **a. Organizational chart of QAPI staff.**
  - **Naming convention: RRQ_Attachment 20_QAPI Org Chart**
- **b. QAPI program committee and subcommittee structure/chart.**
  - **Naming convention: RRQ_Attachment 20_QAPI Committee Structure**
- **c. Describe the delineation of responsibilities between corporate staff and state-level staff.**

a. Key Quality Assessment and Performance Improvement Staff

Three key quality assessment and performance improvement program leaders for Molina Healthcare of Iowa are being hired. These leadership positions are the Associate Vice President, Quality and Risk, Director, Health Equity and Cultural Competency, Manager, Provider Quality and Practice Transformation, Manager, Interventions. The total Full Time Equivalent staff for the quality department include 10 total positions. Support roles within Molina Healthcare of Iowa, include Senior Specialists for interventions (2), Specialists, Provider Quality and Practice Transformation (2), 1 Senior Specialist for compliance, and 1 analyst.

Additional national (corporate) roles support Molina Healthcare of Iowa. These positions focus on HEDIS data collection management and medical record review collection, risk adjustment and data analysis and national interventions program management.

b. The committee description visual (provided after this summary) shows the national and Iowa-specific committee structure for Molina Healthcare of Iowa. In Iowa, Molina's committee structure includes the Compliance Committee that reports to the Molina Healthcare Board of Directors and the Quality Management/Quality Improvement Committee that reports to the Molina Healthcare of Iowa Board of Directors. The internal quality management and quality improvement program Quality Management and Quality Improvement Committee is accountable to and reports to the Board of Directors on a scheduled basis. The Quality Management and Quality Improvement Committee reports the discussion and evaluation of quality improvement activities, findings, recommendations, and actions taken. Network providers also participate in the Quality Management and Quality Improvement Committee, representing the composition of the network.

The Quality Management and Quality Improvement Committee meets at least quarterly to oversee the internal quality assurance and performance improvement program. The committee is responsible for reviewing and approving policies; reviewing, providing input, and evaluating quality improvement activities, providing clinical input to and approving the use of practice guidelines by the provider network; and following up on key findings and required actions.

The committee meeting minutes will document the structure of the meeting and committee activities, findings, recommendations, and actions. Mechanisms are in place to maintain meeting minutes, signatures, and data reflecting decisions, required actions, and discussions by committee members.

All other committees and subcommittees report to the Quality Management and Quality Improvement Committee. This multi-faceted Committee structure includes participation from network providers and representatives from key Molina functional areas. The committee structure also ensures input and participation of network providers from different specialties across Iowa. The subcommittees reporting to Molina Healthcare of Iowa's Quality Management and Quality Committee include the:

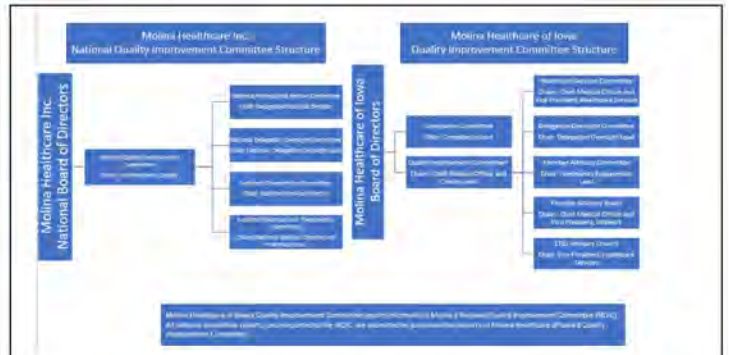
- Healthcare Services Committee
- Delegation Oversight Committee
- Member Advisory Committee
- Provider Advisory Board
- LTSS Advisory Council

Additionally, Molina Healthcare of Iowa facilitates the *Member Advisory Committee* and *Provider Advisory Board*. The *Member Advisory Committee* is comprised of Members and/or the members' designated legal representatives from across the geographic service area under the Contract. The input from the Member Advisory Committee is prioritized to improve service quality and member experience. The Member Advisory Committee meets at least quarterly. Molina will encourage increased member participation through accommodations being provided for virtual participation; distribution of meeting materials in advance of the meeting that are provided in appropriate literacy levels; arrangement of transportation as appropriate, and facilitation of childcare when appropriate.

The *Provider Advisory Board* includes a broad representation of different provider types from the network. At least one primary care practitioner who delivers care for children and adolescents; at least one primary care practitioner who delivers care for adults; at least one obstetrician/gynecologist, at least one psychiatrist, at least one licensed behavioral health clinical professional, at least one substance abuse professional, at least one community-based care coordinator or community case manager, at least one peer support specialist or a behavioral health case manager, and other practitioners, participate in this advisory board. The *Provider Advisory Board* meets quarterly with minutes submitted to the State within thirty calendar days of the Meeting.

The *LTSS Advisory Council*, which meets quarterly, is comprised of LTSS members, authorized caregivers, and LTSS providers to provide their perspectives on key member and provider needs to fully address this key population's health care and services.

The Molina Healthcare of Iowa's Quality Improvement Committee reports with a dotted line relationship to Molina's National Quality Improvement Committee. The National Quality Improvement Committee, with participation from Chief Medical Officers, Vice Presidents, Healthcare Services, and Quality and Risk leads from Molina plans across the country, report to the Molina Healthcare Inc. Board of Directors. Four subcommittees National Clinical Policy Committee, National Delegation Oversight Committee, National Professional Review Committee and the National Pharmacy and Therapeutics Committee, report to the National Quality Improvement Committee.



c. Molina Healthcare of Iowa uses a collaborative multi-functional team located in the state of Iowa and nationally to conduct comprehensive quality improvement activities. This team is designed to ensure Molina Healthcare of Iowa exceeds the state of Iowa quality assessment and performance improvement program requirements.

The AVP, Quality and Risk, located in Iowa, oversees the Molina Healthcare of Iowa team to: 1) implement member- and provider-focused quality improvement interventions that improve the health care and services for our members; 2) develop and execute a cultural competency and diversity strategy to reduce potential disparities in health care; 3) hold and oversee quality improvement and advisory committee meetings to modify programs based on the valuable feedback we receive from members, providers, and community-based organizations; 4) work with the community engagement team to hold Clinic Days and member engagement events, as applicable; and 5) comply with Iowa requirements through data collection, analysis, and submission of mandated reports and performance improvement projects; and 6) participate in state-wide collaborative meetings with Iowa plans.

The national Molina Risk and Quality Solutions teams support the Molina Healthcare of Iowa quality team by implementing the following activities.

- The national Clinical Data Acquisition team oversees performance measurement data collection and medical abstraction for HEDIS and Risk Adjustment. The national team supporting Iowa includes a technical Program Manager, Manager, three medical record collectors, and a data analyst. The national team oversees the implementation of consistent data collection processes and systems to conduct Iowa-specific data collection and performance measurement reporting.

- The national Quality Program Management and Performance team supports the Iowa quality assessment and performance improvement program by: 1) preparing and completing reports, materials, and documents to meet the state of Iowa and NCQA (National Committee for Quality Assurance) accreditation requirements; 2) overseeing the NCQA accreditation process with the local Iowa team; and working with the survey vendor to conduct member and provider satisfaction surveys and preparing and analyzing survey results; performing appointment availability audits to ensure that network providers in Iowa deliver adequate and timely access to health care for our members; and investigating Potential Quality of Care issues. Team members include Senior Specialists, Quality, Program Managers and Specialists who will participate in activities for Iowa.

- The national Member Engagement and Interventions team supports the Molina Healthcare of Iowa quality team through consultation, analysis, and implementation of national and Iowa-based quality improvement interventions. A dedicated Program Manager on this team will support the Molina Healthcare of Iowa quality team.

- The national Health Plan Performance and Provider Engagement team provides a dedicated Regional Director who works with Molina Healthcare of Iowa to offer ongoing support, consultation, and linkage to national Molina activities. This team also develops national provider engagement tools, resources, and programs to support the health plan and network providers.

- The national Risk Adjustment team supports Molina Healthcare of Iowa through implementation of strategies and provision of resources so that our members can receive the right care at the right time. National analysts and program managers help support Molina Healthcare of Iowa.

21. Describe the program integrity and privacy and security structures, and include:

- **a. Organizational chart of program integrity staff.**
  - **Naming convention: RRQ_Attachment 21_PI Org Chart**
- **b. Organizational chart of privacy and security staff.**
  - **Naming convention: RRQ_Attachment 21_Privacy Org Chart**
- **c. Describe the delineation of responsibilities between corporate staff and state-level staff.**
- **d. System(s) used to track program integrity issues (e.g., fraud and abuse, HIPAA-related incidents).**
- **e. Provide a brief description of the program integrity activities conducted by the MCO.**
- **f. Provide a brief description for how the MCO ensures confidentiality of member health information and other confidential data.**

a. RRQ_Attachment 21_PI Org Chart

Molina's Compliance Officer is the individual within the organization who is the primary point of contact for Program Integrity and responsible for ensuring the health plan is abiding by all applicable requirements. The Compliance Officer, in partnership with the Special Investigation Unit (SIU) has the responsibility and authority to report all investigations resulting in a finding of confirmed, credible, or suspected acts of fraud, waste, and abuse (FWA) by providers or members to the Office of Inspector General (OIG), and other state and federal regulatory and/or law enforcement agencies.

The SIU is a corporate solution with staff of 110 full-time employees across the enterprise (corporate and state-level resources). The SIU is led by the VP of Payment Integrity, Fraud, Waste and Abuse (FWA) Programs, and in addition to FWA investigative activities, is responsible for ensuring compliance with all state and federal regulatory requirements related to the detection and prevention of Fraud, Waste and Abuse. The SIU Vice President is supported by (3) three Directors of Operations responsible for the day-to-day operations of the SIU. The team also consists of subject matter experts in coding and clinical medical records, intake and reporting, data analysts and investigators. Staff resource allocation is monitored routinely and will meet the contractual requirements including a Program Integrity Manager, residing in and 100% dedicated to Iowa program integrity efforts. The PI Manager will be supported by investigators, staffed at a ratio of 1 FTE / 50,000 Enrollees. Please see attached organizational chart (RRQ Attachment 21_PI Org Chart) for reference.

Additionally, Molina has a dedicated Payment Integrity department, including a SIU, established to focus on the prevention, detection, investigation, and reporting of suspected health care related FWA to reduce and prevent unnecessary or inappropriate usage of Medicaid funds. In partnership with various departments such as Claims Recovery, Provider Network, Credentialing, and Utilization Management, our payment integrity initiatives include the assessment of providers for compliance with billing, coding, and clinical guidelines to ensure appropriate and effective payment integrity solutions centered on deterring and preventing FWA.

b. RRQ_ Attachment 21_Privacy Org Chart

c. Corporate and state-level staff work in partnership to achieve all requirements under program integrity. State-level staff are responsible for all day-to-day operations and requirements, while corporate staff support ongoing needs such as reporting, investigations, and other administrative needs.

d.

- Navex Global-Compliance Alertline (Hotline)
- Inovaare- Compliance central (Compliance Management Tool)
- CHAMP (HIPAA Management Tool)
- Healthcare Fraud Shield (SIU Management Tool)

e. Molina is committed to complying with all applicable requirements and standards under all applicable federal and state laws, regulations, contractual requirements, and standards. The Compliance department maintains an effective compliance program that focuses on honesty, integrity, and making professional and ethical decisions and includes measures to prevent, detect, and correct non-compliance. The program includes but is not limited to:

- Written Policies and Procedures, Compliance Plan, and Standards of Conduct;
- Designation of a Compliance Officer and Compliance Committee;
- Effective Training and Education;
- Effective Lines of Communication;

- Well-Publicized Disciplinary Standards;
- Routine Monitoring, Auditing, and Identification of Compliance Risks; and,
  Prompt Response to Compliance Issues.

In addition, the Payment Integrity department maintains a program to ensure that external payments (providers, subcontractors, vendors, etc.) and all internal processes and payments (e.g., employees, internal controls, etc.) are appropriate and accounted for in all respects. Molina uses various methods for preventing and detecting member, provider and subcontractor fraud, waste, and abuse in the administration and delivery of services related to the Medicaid contract, including but not limited to:

- Investigation of oral or written reports by providers, members, and employees;
- Claims audits and analysis;
- Claims system edits and flags;
- Software analysis and reporting;
- Review of member and provider utilization patterns; and,
  Audits of providers' billing practices and service patterns to prevent and detect potential fraud, waste, and abuse.

f. Molina is committed to satisfying every state and federal law protecting the privacy of the personal and health information of our members. Molina has implemented effective privacy and security policies and procedures to ensure the confidentiality of member health information and other confidential information. Molina limits how its staff may use and disclose member information in accordance with HIPAA regulations and other requirements. Use or disclosure of member information for other purposes requires that the member's authorization is obtained. All Molina staff must sign a Confidentiality Agreement upon hire and annually thereafter. New hires are trained in privacy and security upon joining Molina and annually thereafter.

Molina's security program is aligned with HIPAA and National Institute of Standards and Technology (NIST) standards. Access to Molina's network requires multi-factor authentication. All member health information is encrypted in motion and at rest. Molina's subcontractors must contractually agree to the same standards and sign business associate agreements. Access to Molina's systems that contain member information is limited to the minimum necessary information required based on the staff member's role. Access to member information is reviewed and re-entitled annually.

22. Describe the financial management structure, and include:

a. Organizational chart of financial management staff.

- **Naming convention: RRQ_Attachment 22_Finance Org Chart**

b. Provide a brief description of the process for assessing and maintaining financial solvency.

a. RRQ_Attachment 22_Finance Org Chart

The financial management of Molina Healthcare of Iowa will be centered around a local health plan finance team specifically assigned to the state of Iowa. This team will consist of a Market CFO, a Finance Director, two Managers and two senior analysts. This team will be responsible for the required financial deliverables, including the MRT. In addition, they will be responsible for quarterly forecasting and planning, tracking of administrative expenses, analytic support for health plan leadership, and coordination for all corporate financial teams helping to support the market.

Financial support from Molina Healthcare Inc. will also be provided to the health plan finance team, including the following areas:

- Actuarial: Monthly reservation including IBNR, medical cost forecasting on quarterly basis, and evaluation of capitation adequacy.
- Financial Planning & Analysis: Coordination of companywide quarterly and annual forecast process, cash flow forecasting and analysis, and long-range planning.
- Accounting: Premium reconciliation, general ledger entries, account reconciliation and financial controls (including SOX, and audit support).
- Medical Economics: Medical cost trend and analysis; ideation, implementation and tracking of medical savings opportunities; analytic support on network pricing.
- Treasury: Responsible for investment of Molina Healthcare Inc. resources, assuring available funding for all state solvency requirements.

b. Molina's financial systems are structured in such a way that each contract has a dedicated Company number and an underlying set of business units. This structure allows for the tracking of the financial performance of each contract.

The following reports will be submitted to document compliance.

1. An Audited Financial Statement specific to the Medicaid contract on an annual basis in accordance with generally accepted accounting principles and generally accepted auditing standards (I.2.19)

2. A copy of the Annual Audited Financial Report, as submitted to and required by the Iowa Insurance Division (I.2.20)

3. Copies of the quarterly NAIC financial reports and a reconciliation completed by the independent auditing firm that conducted the annual audit (I.2.21)

Molina Healthcare, Inc. performs routine monitoring of the capital adequacy of each of its health plans. On a quarterly basis, Molina compares the quarter-end capital and surplus to the estimated year-to-date or year-end authorized control level ("ACL"). In estimating the ACL, Molina considers each health plan's actual results to date, and the most recent available forecast for future months. The results of such analysis are used to determine if any health plan will need a capital infusion from Molina during the year. Conversely, the results may indicate that there is excess capital and surplus that may be paid to Molina as a dividend following appropriate approvals. This assessment is updated at least quarterly by the Corporate

Finance/Accounting staff, with input from the health plans whenever necessary. This control shall apply to Molina Healthcare of Iowa.