

Governor's Medicaid Fraud Elimination Task Force

Report and Recommendations

Submitted to Governor Kim Reynolds

Pursuant to Executive Order 20 (July 1, 2026)

October 2026

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Executive Summary

The Task Force thanks Governor Kim Reynolds for convening it and for making the elimination of Medicaid fraud a priority of her administration. Executive Order 20, signed July 1, 2026, created the Governor's Medicaid Fraud Elimination Task Force to focus the State's resources on eliminating fraud, waste, and abuse, so that Medicaid dollars reach the Iowans who need and qualify for them.¹

The Governor acted alongside a national effort. The President directed federal action against Medicaid waste, fraud, and abuse on June 6, 2025, and Executive Order 14395 created a federal Task Force to Eliminate Fraud in March 2026. CMS has since asked states to revalidate high-risk providers, announced that HHS-OIG will review every state's Medicaid Fraud Control Unit, and imposed a moratorium on new home health and hospice enrollment, which Iowa adopted.²

The Attorney General chairs the Task Force. Its members represent the Department of Health and Human Services, Iowa Medicaid, the Department of Inspections, Appeals, and Licensing, the Medicaid Fraud Control Unit, the Department of Public Safety, the Department of Management, the Governor's Office, and Iowa's three managed care organizations: Wellpoint Iowa, Iowa Total Care, and Molina Healthcare of Iowa. Five work groups carried out the Task Force's work. Each chapter of this report presents one workgroup's findings and recommendations.

The Executive Order's Goals

Executive Order 20 set six mission objectives and asked the Task Force for two sets of recommendations. This report answers each of them.

Order	Executive Order 20 directs the Task Force to...	Addressed in
Mission A	Strengthen federal alignment by cooperating with CMS and federal program integrity initiatives and aligning with federal actions to suspend enrollment of new high-risk providers.	Chapter 1
Mission B	Increase fraud awareness by promoting reporting resources, public accountability, and the incentives for reporting available under Iowa law.	Chapter 2
Mission C	Invest in program integrity technology through a fund capitalized by recovered dollars.	Chapter 4
Mission D	Support managed care organizations' provider network management.	Chapter 5

¹Iowa Exec. Order No. 20 (July 1, 2026).

²Id. (recitals); Exec. Order No. 14395 (Mar. 16, 2026).

Order	Executive Order 20 directs the Task Force to...	Addressed in
Mission E	Establish an Integrity Quality Initiative and an Applied Behavior Analysis Center of Excellence focused on high-risk services and electronic visit verification.	Chapter 3
Mission F	Enhance the methods members of the public use to report suspected Medicaid fraud.	Chapter 2
Rec. A	Recommend a comprehensive statewide strategy to eliminate Medicaid fraud, waste, and abuse.	All chapters
Rec. B	Recommend how to leverage federal funding for Iowa's MFCU and structure its operations more effectively and efficiently.	Chapter 1

Principal Recommendations

Chapter 1: MFCU Optimization

Iowa's Medicaid Fraud Control Unit brings more criminal cases per employee than any unit in the country. But since FY 2013, Iowa Medicaid spending has grown 129 percent while the unit's budget grew 31 percent, and its recoveries fell by more than three-quarters.

Chapter 1 recommends adding a civil enforcement component to the Attorney General's Office and then assessing how to best structure the unit components within the Department of Inspections, Appeals, and Licensing. Currently, 49 of the nation's 53 units sit within the Attorney General's office and these additions will bring Iowa closer to that alignment. Recommendations also include more than doubling it, with dedicated civil and criminal prosecutors, more investigators, auditors and analysts, and a nurse investigator; giving investigators full law-enforcement authority; building an in-house False Claims Act practice; cross-designating unit attorneys as Special Assistant U.S. Attorneys; and funding modern analytics. The federal government pays 75 percent of the cost. The chapter also identifies statutory changes, among them tougher penalties for Medicaid fraud, priority for Medicaid restitution, investigative subpoena authority, and new state anti-kickback and civil penalty laws.

Chapter 2: Medicaid Fraud Public Awareness and Reporting Channels

Iowans cannot report fraud they do not recognize, through channels they cannot find. Chapter 2 recommends that the Iowa HHS website define Medicaid fraud and explain how to report it; that the State adopt clear communication protocols for media and stakeholders that explain who investigates fraud and what the State can disclose; that HHS, DIAL, the Department of Public Safety, and the Iowa Insurance Division formalize a joint communications strategy, including promoting IowaFraudFighters.gov; that each managed care organization maintain a clear,

documented fraud-reporting process; and that Iowa HHS release a plain-language video explaining what fraud is, how to report it, and how it is investigated.

Chapter 3: Quality and Program Integrity in High-Risk Medicaid Services

Chapter 3 addresses the services where fraud risk runs highest. It recommends that Iowa Medicaid build on its existing program integrity work in three ways: by using common, data-driven risk indicators to target review of high-risk services across fee-for-service and managed care, while recognizing that unusual utilization does not by itself indicate fraud; by strengthening the quality, governance, and claim-level linkage of electronic visit verification data; and by standardizing review practices across payment systems, using the standardized audit approach under development for applied behavior analysis services as a model.

Chapter 4: Technology and Data Analytics

Chapter 4 recommends that recovered dollars continue to flow to Medical Assistance and that HHS create a Program Integrity Technology Unit within the existing HHS IT Fund, giving program integrity technology its own spending record that can be measured against the recoveries it produces, without a new fund or administrative layer. It also recommends expanding advanced analytics, including stronger eligibility verification using federal data such as the Social Security Death Master File, electronic provider enrollment, and pre- and post-payment surveillance of high-risk services, and putting newly expanded HHS-OIG analytics to work in joint Program Integrity and MFCU workflows.

Chapter 5: MCO Network Management

Chapter 5 recommends that Iowa Medicaid confirm that providers in managed care networks are legitimate and actively serving members, using encounter data, phased provider revalidation, secret-shopper surveys, and directory-accuracy tools; that Program Integrity, the MFCU, and the managed care organizations continue their quarterly meetings, with joint case review and training to improve referral quality; and that Iowa Medicaid strengthen independent oversight of networks through automated validation, targeted audits, and modernized network adequacy standards, which have not been updated since 2016.

The Path Forward

Many of these recommendations can begin now under existing authority. Others require appropriations or legislation, most of them identified in Chapter 1. The Governor may direct the responsible agencies to begin implementation via executive order or other means and may even go so far as to call a special session to work with the Legislature to enact the statutory changes this report identifies.

Chapter 1: MFCU Optimization

Summary

Iowa's Medicaid Fraud Control Unit produces results far beyond its size. In federal fiscal years 2019 through 2021, the unit secured 80 indictments and 79 convictions with eight staff. Similarly sized units averaged 21 indictments and 19 convictions.³

But the unit cannot execute its own confidential search warrants, and it has no civil litigators to recover money under the Iowa False Claims Act. And the referrals that should feed it from Iowa's managed care organizations are not growing.

Nor has Iowa scaled the unit to the program it polices. Between FY 2013 and FY 2025, Iowa Medicaid spending grew 129 percent, from \$3.81 billion to \$8.73 billion. The unit's budget grew 31 percent, its funded staff never exceeded ten, and its recoveries fell from \$24.4 million in FY 2014 to \$2.4 million in FY 2025.⁴

So the Committee recommends that Iowa create a civil fraud component to the Office of the Attorney General and grow it to reflect the program's increased size, with dedicated civil and criminal prosecutors, more investigators, four auditors and analysts, and a nurse investigator. The federal government pays 75 percent of MFCU costs, so the State can improve that capacity at a quarter of the price.⁵ Increasing the staffing to 24 staff at a similar pay scale could cost about \$550,000 to the State and draw \$2,450,000 in total federal funding (an increase of \$1.43 million in new federal dollars). Each dollar spent by Iowa taxpayers could return \$16—or perhaps even more. And it is plausible that the increase and matched increase civil enforcement will pay for—or more than pay for—the increase in staff.

Iowa should also stand up a State Medicaid Fraud War Room on the CMS model so that suspect providers stop getting paid while the unit builds its cases. The Committee also recommends targeted statutory changes, summarized under Legislative Changes.

The Committee's Charge

Executive Order 20 gives this Committee two assignments. The first is to “Strengthen Federal Alignment” by continuing to “cooperate with CMS and federal program integrity initiatives.” The second is to recommend ways of “Leveraging federal funding resources to assist Iowa's Medicaid Fraud Control Units (“MFCU”) and

³HHS-OIG, Iowa Medicaid Fraud Control Unit: 2021 Inspection, OEI-07-21-00340, at 6 & nn.21–22 (June 2022) (comparing units with four to ten staff).

⁴HHS-OIG, Medicaid Fraud Control Unit Statistical Charts, FY 2013–FY 2025.

⁵42 U.S.C. § 1396b(a)(6) (75 percent federal financial participation for established units).

examining a more effective and efficient manner to structure Iowa's MFCU operations.”⁶

What the Committee Found

Iowa Medicaid has more than doubled while the unit has stood still.

Between FY 2013 and FY 2025, Iowa Medicaid spending grew from \$3.81 billion to \$8.73 billion, an increase of 129 percent, peaking at \$8.87 billion in FY 2024. The unit did not grow with it. Funded staffing held between seven and ten positions, averaging 8.55, and the unit's grant budget rose only 31 percent, from \$1.04 million to \$1.36 million. As a share of Medicaid spending, the unit's budget fell by nearly half, from 0.027 percent to 0.016 percent.⁷

Results followed resources. Criminal fraud convictions averaged 19.4 a year from FY 2013 through FY 2024, peaking at 33 in FY 2015 before falling to 7 in FY 2022 and 10 in FY 2024. Civil settlements and judgments fell from 22 in FY 2016 to 4 in FY 2023 and 6 in FY 2024. And recoveries dropped from \$10.72 million in FY 2013 and \$24.40 million in FY 2014 to \$2.22 million in FY 2024 and \$2.36 million in FY 2025.

Iowa's peer states on staff spending each run significantly smaller programs: Idaho, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, and Wyoming, are all far smaller than Iowa. With its currently filled positions, each Iowa MFCU employee polices nearly \$1 billion in Medicaid spending. A bigger program means more room for improper billing, kickbacks, and neglect. Flat recoveries against a doubled program do not mean fraud has receded. They mean the unit lacks the people to find it.

The unit's legal tools are weaker than its mission requires.

Iowa Code § 10A.403 gives MFCU investigators some of the powers of peace officers. In practice, that lets them conduct surveillance and seek warrants. But they cannot execute warrants themselves and must enlist local or federal officers to do it.⁸ Federal partners described the unit as lacking law-enforcement authority for that reason. The unit also has no prosecutorial authority; it refers criminal cases to Iowa's 99 county attorneys or the two U.S. Attorneys' offices. And under DIAL it holds only administrative subpoena power. Despite that, MFCU has run a very efficient unit that leads the country in its criminal prosecution referrals and subsequent convictions. Improving the legal tools available will empower the MFCU unit to take its efficient performance and achieve even greater results.

⁶Iowa Exec. Order No. 20, Mission ¶ A; Recommendations ¶ B (July 1, 2026).

⁷HHS-OIG, Medicaid Fraud Control Unit Statistical Charts, FY 2013–FY 2025.

⁸Iowa Code § 10A.403.

Iowa leaves civil money on the table because the unit has no False Claims Act practice.

Most of the unit's civil recoveries come from nationwide settlements negotiated by the National Association of Medicaid Fraud Control Units and the Department of Justice. Iowa controls neither their pace nor their priorities. When a U.S. Attorney declines a case that still shows fraud, no routine path sends it to the Attorney General for action under the Iowa False Claims Act, chapter 685.

The imbalance is shown in the numbers. Person for person, Iowa's unit ranked first in the nation in FY 2025 in both indictments and convictions per staff member. Yet it ranked 29th in recoveries per staff member, and its \$2.36 million in FY 2025 recoveries was less than half the median state's. In FY 2024, 27 of Iowa's 34 indictments, or 79 percent, involved patient abuse—which meant a small share was provider fraud. The seven provider-fraud indictments produced \$126,642 in criminal recoveries, against a national median of \$601,379. From FY 2013 through FY 2024, nearly half of Iowa's convictions (207 of 440, or 47 percent) were for abuse or neglect.

Civil enforcement is where the money is, and the Iowa False Claims Act makes it far easier to reach. A criminal case requires proof of specific intent beyond a reasonable doubt, a heavy lift against corporate defendants who claim the billing rules were ambiguous. The False Claims Act requires only that a defendant act knowingly, which includes deliberate ignorance or reckless disregard, and it carries treble damages and civil penalties.⁹ Because Iowa's act meets federal standards, the State also keeps an extra ten percentage points of the Medicaid money it recovers.¹⁰ In FY 2024, non-global civil cases produced 92 percent of the unit's recoveries. Yet the unit has only one Assistant Attorney General, who must advise investigators, coordinate with 99 county attorneys, and monitor national litigation. That leaves no capacity to develop whistleblower cases or to litigate against large health-care entities.

Iowa also lacks two tools nearly every peer state has: a Medicaid-specific anti-kickback statute and a state civil monetary penalties law outside the False Claims Act. If the Legislature enacted those laws, it would let the State penalize referral schemes in managed care, laboratories, and medical equipment that fall below federal enforcement thresholds.

⁹Iowa Code §§ 685.1, 685.2(1).

¹⁰42 U.S.C. § 1396h (increasing a State's share of recoveries under a qualifying state false claims act).

More, recoveries do not return to the unit. After the federal share comes out, restitution goes to Iowa Medicaid and the remainder to the Medicaid fraud fund under § 249A.50(3).¹¹

Referrals from managed care are low.

Historically, about 95 percent of Iowa Medicaid runs through three managed care organizations, which serve roughly 15,000 enrolled providers. The MCOs and Iowa Medicaid are the only sources contractually bound to refer suspected fraud. Yet the MCOs made only 21 referrals last year, and the unit accepted five.

In July 2026, 15 referrals yielded three opened cases. Many referrals describe documentation problems rather than fraud.¹² Citizen and qui tam reporting, meanwhile, was described as “very inefficient.” Caution is warranted, however, in that pressing MCOs for volume alone may lead to lower quality referrals.

The unit does not use the highest data tools that generate proactive cases.

One auditor handles every data request from investigators and from nationwide civil cases, which leaves data mining as a last priority. The unit has no specialized analytics software, and a single pull from the State’s aging data warehouse for a single code across providers could take up to 30 minutes. In state fiscal year 2025 the unit logged 11.5 staff hours on data mining.¹³ Federal partners offered to close much of that gap. HHS-OIG can provide outlier and peer-comparison tools built on CMS’s national Medicaid data, and CMS’s War Room analytics already flag eight to ten high-risk service areas for each state.

Iowa does not lack authority. The unit has long held HHS-OIG approval to mine Medicaid claims data, one of 26 units approved as of January 2026, and recent HHS-OIG guidance broadens what units may do.¹⁴ But with one auditor and no data scientists, the unit’s 11.5 hours of data mining in FY 2025 cost \$484.73 and produced no investigations and no recoveries. The barrier is human capital and manpower.

Federal partners are ready to do more, and the leading states show how.

HHS-OIG has no resident agents in Iowa. It reported that the unit partners on only a small share of open federal Medicaid cases in Iowa and on no state cases. It offered joint training, an analytics demonstration, data access, surge staffing, and an MOU.

¹¹Iowa Code § 249A.50(3).

¹²Committee meeting (Aug. 10, 2026).

¹³SFY 2025 Annual Report, at 4; Committee meeting (Aug. 10, 2026).

¹⁴42 C.F.R. § 1007.20; HHS-OIG, Medicaid Fraud Control Units Annual Report: Fiscal Year 2025, at 10 n.11 (OEI-09-26-00140, Mar. 2026); HHS-OIG Policy Transmittal 2026-1, Permissible Data Mining Activities.

Ohio, Indiana, and Arizona set the standard: monthly or biweekly meetings with federal partners, routine deconfliction, and aggressive prosecutors on both sides. Arizona's Medicaid inspector general works under three MOUs with its MFCU and hosts an MFCU investigator two days a week. Florida convenes agencies, law enforcement, and MCOs quarterly, and Ohio has built a state-level fraud war room.¹⁵

Comparator States show what scale buys.

Nevada is Iowa's closest peer. Both states have about 3.2 million residents, managed care, a state False Claims Act with whistleblower provisions, and access to Medicaid data. The results diverge. From FY 2013 through FY 2024, 93 percent of Nevada's convictions were for financial fraud, against half of Iowa's, and Nevada obtained \$28.5 million in criminal restitution, nearly seven times Iowa's \$4.08 million. In FY 2025, Nevada secured 36 convictions and \$18.5 million in recoveries, nearly eight times Iowa's \$2.36 million, or about \$926,000 per staff member against Iowa's \$236,000.¹⁶

Other similarly sized programs have staffing sizes closer to the recommended size here. Arkansas has the same program budget as Iowa, around \$8 billion, with 22 staff. Over the last nine years (FY 2016 – FY 2024), Arkansas returned civil monetary recoveries valued at \$77 million—about 2.3 times Iowa's return. So too Oklahoma, West Virginia, and South Carolina, which all have similarly sized programs to Iowa and have returned 2.2x, 2.1x and 1.7x the civil monetary recoveries that Iowa has over that same period.

Recommendations

The eight recommendations below reflect the Committee's settled view. Items marked "Study" in the legislative table, and those that follow it, need more study.

1. Create the MFCU Civil Fraud Component in the Office of the Attorney General.

Nearly every other state houses its MFCU in the attorney general's office, and Iowa is one of only a handful that do not. Creating a civil fraud enforcement unit that includes adequate attorneys and support staffing would allow Iowa to reap the returns of stronger civil fraud enforcement. And that approach could allow the current unit to continue what it does best: criminal enforcement. Ultimately determining the best allocation of staff is a question that should yield further

¹⁵*Id.*

¹⁶HHS-OIG, Medicaid Fraud Control Unit Statistical Charts, FY 2013–FY 2025.

discussion, with the caveat of the need for more civil fraud enforcement attorneys in the Attorney General's office.¹⁷

2. More than double the unit, with prosecutors, investigators, and analysts in balance.

The Committee recommends a unit of 24. Six staff attorneys would split evenly between civil cases housed in the Attorney General's Office (Iowa False Claims Act matters and national qui tam settlements) and criminal cases (fraud, abuse and neglect, and drug diversion), all cross-trained to handle either. Investigators should ideally include ILEA-certified former detectives or certified fraud examiners.

Position	Filled today	Budgeted today	Proposed
MFCU Director	1	1	1
Chief Investigator / Evidence Custodian	0	1	1
Staff attorneys, civil (Iowa FCA and global cases)	0	0	3
Staff attorneys, criminal	1	1	3
Investigators	5	6	8
Nurse investigator (RN or LPN)	0	0	1
Auditors / data analysts	1	1	4
Paralegals	1	1	2
Administrative staff	0	0	1
Total	9	11	24

Current figures are as reported by MFCU leadership to the Committee. The proposed investigator count is a working figure.

The cost is modest. Iowa contributes about \$340,000 a year in state funds today. At the unit's current cost per position, a 24-position unit would cost roughly \$3.3 million a year, of which Iowa's share would be about \$800,000, before the pay adjustment in Recommendation 3. Every added state dollar draws three federal dollars, and fraud

¹⁷42 U.S.C. § 1396b(q) (unit must be "separate and distinct" from the single State agency).

units nationally returned \$4.64 for every dollar spent in FY 2025.¹⁸ That means that if Iowa achieves this increase in staffing it would likely only cost the state around \$550,000. That increase—especially accompanying civil fraud enforcement—will create an enormous return on investment for Iowans. Going forward, the unit's budget should grow with Medicaid spending rather than stand still.

3. Review MFCU pay grades to support recruitment and retention.

Turnover drove the 2021 finding, and the unit still runs vacancies. DIAL should work with the Department of Administrative Services (“DAS”) to evaluate MFCU job classifications and pay grades to ensure compensation is competitive and not a factor in losing qualified staff.

4. Give investigators authorization to achieve full law-enforcement authority, including firearms.

Investigators should execute their own warrants. ILEA-certified investigators should be authorized to carry firearms, particularly for drug-diversion work, and the unit should receive the training and qualification resources to keep that certification current.

5. Build an in-house False Claims Act practice.

The unit should adopt written procedures for referring matters to the Attorney General under chapter 685, and the three civil attorneys housed in the Attorney General's office should pursue cases that federal prosecutors decline. That ends Iowa's dependence on national settlements for its civil recoveries. The Legislature should also enact a state Medicaid anti-kickback statute and an administrative civil monetary penalties law, and the civil attorneys should enforce them.

6. Cross-designate MFCU attorneys as Special Assistant U.S. Attorneys and formalize the federal partnership.

Cross-designated MFCU attorneys could work alongside the five new grant-funded fraud SAUSA positions in the Northern and Southern Districts of Iowa. The unit should also sign an MOU with HHS-OIG, hold monthly joint meetings that include both U.S. Attorneys' offices, schedule the joint training HHS-OIG has offered, and adopt the HHS-OIG and CMS War Room analytics.

7. Fund modern data, case-management, and litigation tools.

The unit needs AI-assisted analytics software; an investigator case-management system with ad hoc reporting for grant metrics; licenses for the Attorney General's attorney case-management system; cloud storage for case files and evidence; an

¹⁸HHS-OIG, Medicaid Fraud Control Units Annual Report: Fiscal Year 2025, at 1 (OEI-09-26-00140, Mar. 2026).

aggressive litigation budget; and travel and training funds. Additional non-staff costs, including technology, could cost about \$1 million dollars, which given the 75% match would net out to an estimated \$212,500 to \$250,000 net cost in State funds.

8. Longer term: Stand up an Iowa Medicaid Fraud War Room and route referrals through it.

CMS has issued standard operating procedures for state Medicaid fraud war rooms, and Iowa should adopt them. The model seats the Medicaid or program integrity director as chair, with an analytics team, Medicaid legal counsel, a provider enrollment officer, CMS, and an MFCU liaison at one recurring table. Analysts present a ranked list of high-risk providers; the group deconflicts each one with the MFCU and federal partners; and the War Room acts by tier.

For the strongest cases, the procedures call for a payment suspension under 42 C.F.R. § 455.23 within 24 hours, a same-day MFCU referral, and a federal exclusion referral within five business days. CMS supplies the agenda, case brief, action log, data request, and exclusion referral templates.¹⁹

The point is speed. Regulatory action and criminal investigation run in parallel, so Iowa stops paying a suspect provider while the MFCU builds its case. The War Room should also become the front door for MCO referrals. The Task Force should require the MCOs to present their fraud, waste, and abuse efforts at a public meeting, measure each plan against CMS managed care program reports, and benchmark Iowa against the 10 to 12 states with \$6 to \$12 billion in Medicaid spending. Iowa Medicaid would lead the War Room, so the Committee will coordinate with the committees addressing program integrity.

Legislative Changes

The following statutory changes would carry out these recommendations and could be accompanied by Executive action starting the process to implement several of these reforms.

¹⁹CMS Center for Program Integrity, State Medicaid Fraud War Room Standard Operating Procedures §§ 2–4 & Templates A–E.

#	Change	Iowa Code	Tier
1	Create the MFCU civil unit in the Office of the Attorney General.	ch. 10A to ch. 13	Recommend
2	Confirm availability of full peace-officer authority, including executing warrants and carrying firearms for ILEA-certified investigators.	§§ 10A.403, 801.4	Recommend
3	Make Medicaid fraud a class D felony, consistent with insurance fraud, and a class C felony above \$10,000.	§ 249A.50–.51 (cf. § 507E.3)	Recommend
4	Make Medicaid restitution category “A” restitution; leave MFCU investigative costs in category “B.”	§ 910.2	Recommend
5	Keep the current period in § 249A.42 rather than shortening it to 24 months; adopt a five-year look-back by Medicaid rule.	§ 249A.42 (no change)	Recommend
6	Give the MFCU investigative subpoena authority, including confidential subpoenas modeled on Iowa R. Crim. P. 2.516.	ch. 10A/13; ch. 17A	Recommend
7	Enact a state Medicaid anti-kickback statute and an administrative civil monetary penalties law.	new; ch. 249A	Recommend
8	Direct a share of the Medicaid fraud fund to the MFCU, subject to federal program-income rules.	§ 249A.50(3)	Study
9	Review the False Claims Act public-disclosure bar.	§ 685.3(5)(c)	Study
10	Authorize concurrent MFCU prosecutorial authority with county attorneys.	ch. 13	Study

“Recommend” reflects the Committee’s settled view; “Study” marks items needing further analysis before the final bill.

Items for Further Consideration

Three ideas deserve more work, and each belongs partly to other committees. First, Iowa could tie the performance measures of Medicaid leadership to program integrity results, a design point CMS and academic advisors pressed. Second, Iowa could screen high-risk provider types more aggressively at enrollment and revalidation, including in-person site visits, as Arizona did when it removed large numbers of unlicensed or nonexistent providers. Third, the unit should pursue direct access to CMS's national Medicaid data while HHS addresses the age and speed of the State data warehouse.

Conclusion

The Task Force should recommend that the Governor and Legislature enact a civil fraud enforcement component in the Attorney General's Office, more than double MFCU's staff, and enact the statutory changes identified above.

Chapter 2: Medicaid Fraud Public Awareness and Reporting Channels

To enhance methods for the public to report suspected Medicaid fraud, we make the following recommendations.

1. The Iowa HHS website should outline the definition of fraud and how to report it.

A clear, accessible definition of fraud and transparent reporting instructions reduce confusion, increase appropriate referrals, and enhance public trust. Many members of the public do not understand what qualifies as fraud or how their reports are used. When reporting pathways are confusing or inconsistent, people are less likely to report concerns, and inaccurate reports may increase administrative burden. A well-structured website improves accuracy, accessibility, and engagement.

Supporting content:

- **Iowa HHS has strengthened its approach through:**
 - Launching a cleaner, more user-friendly Medicaid fraud reporting webpage, including a linked Program Integrity (PI) page.
 - Converting a previously PDF-only fraud reporting form into a secure Microsoft Form, improving accessibility and ease of use.
 - Simplifying how to report fraud and clarifying what information can be shared when fraud-related inquiries arise.
- **Public Reporting Channels:**
 - **Online:** <https://hhs.iowa.gov/medicaid/how-report-medicaid-fraud>
 - **Member Fraud Hotline:** 877-347-5678
 - **Provider Fraud Hotlines:** 877-446-3787 or 515-256-4615
 - **Federal HHS-OIG Hotline:** 1-800-HHS-TIPS
 - MCOs have their specific reporting process

All reports are reviewed by Program Integrity. Credible allegations are referred to the Medicaid Fraud Control Unit (MFCU). Iowa uses provider screening, audits, data analytics, and managed care oversight to prevent improper payments.

2. The state should have clear communication for media and stakeholders that outlines roles and responsibilities for investigating fraud and for public reporting.

Without consistent messaging, responses may vary across departments or staff, increasing risk of releasing protected information, creating public confusion, or misrepresenting the scope of ongoing investigations. Clear communication protocols

ensure legal compliance, protect confidential data, and promote public understanding of what the state can and cannot disclose.

Supporting content:

- **Media Guidance—Inquiries About Member Fraud:**
 - Iowa HHS cannot confirm or deny whether there is or has been an investigation of fraud with respect to an individual because state and federal law protect the identifying information of an individual who is a recipient of medical assistance.
 - Legal references: 42 U.S.C. § 1396a(a)(7), HIPAA, Iowa Code § 217.30
- **Inquiries About Provider Fraud:**
 - Determine the status of any referral to the MFCU:
 - If MFCU has rejected the referral or concluded it without action and returned it to Medicaid, PI may confirm an internal investigation.
 - If the case is still under MFCU investigation or has not yet been referred, PI will provide case-specific direction on the appropriate response.
- **Data Clarity Statement:**
 - The table on the Iowa HHS website reflects internal administrative referrals PI processed. It does not reflect total statewide prosecutions or convictions by DIAL/MFCU.
- **General Public Statement on Fraud Prevention:**
 - Iowa Medicaid tracks fraud, waste, and abuse through federal reporting and internal processes. National statistics are found in the MFCU Annual Report. Anyone who suspects Medicaid fraud, waste, or abuse can report it online, via member or provider hotlines, or through the Federal HHS-OIG Hotline. Iowa uses provider screening, audits, data analytics, and managed care oversight to prevent improper payments and has recovered more than \$109 million since FY21.

3. State agencies should formalize a joint communications strategy.

The Iowa Department of Health and Human Services (HHS), the Department of Inspections, Appeals and Licensing (DIAL), the Department of Public Safety (DPS) and the Iowa Insurance Division (IID) all play a role in preventing, reporting and prosecuting fraud. Together, these state agencies will implement a consistent messaging approach, ensuring clarity for the public about who to contact and constitutes reportable fraud. A coordinated strategy ensures statewide consistency,

improves public understanding, and increases reporting accuracy. Shared resources reduce duplication and leverage collective expertise. Each agency will cross reference, share and promote materials, social media and other communications resources.

With posts like the example below, the state is reinforcing its efforts to protect the Medicaid program by encouraging all Iowans to help prevent and report fraud. Additional messaging will remind the public to:

- Safeguard their Medicaid information,
- Stay alert for inaccurate or suspicious medical activity,
- Ignore unexpected calls, texts, or emails requesting personal information, and
- Promptly report anything concerning

The state is also directing residents to use the Iowa Medicaid Fraud Tip Form or the dedicated hotlines for members, providers, and federal reporting as part of this ongoing fraud-prevention initiative.

The state should also actively promote resources like <https://iowafraudfighters.gov/> that helps Iowans recognize, avoid, and report scams. The site provides simple tools, tips, and resources to protect people—especially older adults—from investment, consumer, and Medicare-related fraud. It also connects the public with the right agencies to report suspicious activity and offers community events and educational materials to help keep Iowans safe.



4. Each Managed Care Organization (“MCO”) should have a clear and well-documented process for reporting fraud.

MCOs serve as a primary point of contact for members and providers. When reporting requirements are unclear or vary widely across MCOs, important information may be delayed or lost. A standardized, documented reporting process ensures timely referrals, improves oversight, and aligns MCO practices with state expectations. This also supports training, audits, and federal compliance requirements.

- Iowa Total Care communicates about Fraud, Waste, and Abuse through a comprehensive set of resources designed to reach both members and providers where they are. Their strategy includes website tools, training materials, handbooks, audit-based verification, provider education events, regular communication channels, and community outreach. Collectively, these efforts promote program integrity, support early identification of potential fraud, and provide clear, accessible reporting pathways.
- Molina Healthcare of Iowa uses a structured, multi-platform strategy to educate providers and members about identifying and reporting Fraud, Waste, and Abuse. Their approach integrates policy documents, training, digital resources, and recurring communications to ensure consistent awareness and compliance.
- Wellpoint communicates about Medicaid fraud by defining fraud, waste, and abuse; giving real-world examples to help members and providers recognize suspicious activity; offering simple prevention tips like safeguarding ID cards and reviewing Explanation of Benefits statements; monitoring provider billing and partnering with investigators to detect unusual patterns; and providing straightforward ways to report concerns through Member Services, online forms, and fraud hotlines, with these expectations reinforced through both the provider manual and the member handbook.

5. Iowa HHS should develop and disseminate a plain-language video tutorial that outlines what fraud is how to report it and how it's investigated.

Iowa HHS is currently producing a plain-language video that will increase accessibility for individuals with low literacy, limited English proficiency, or disabilities. It also promotes trust by showing the process transparently. Video tutorials can be shared on social media, partner websites, and community organizations to reach wider audiences.

Chapter 3: Quality and Program Integrity in High-Risk Medicaid Services

Recommendation

Iowa Medicaid should **explore opportunities to strengthen quality and program integrity oversight for high-risk Medicaid services**, building on program integrity work already underway.

Iowa Medicaid has already begun significant work in this area. Recent analyses have identified unusual billing and documentation patterns in high-risk service providers. Medicaid has also evaluated Electronic Visit Verification (EVV) data and identified opportunities to improve its use as a program integrity tool.

This work provides an opportunity for Medicaid to consider whether additional statewide policies, tools, or oversight strategies could improve consistency and strengthen program integrity while preserving access to medically necessary, person-centered services.

1. Strengthen Risk-Based Approach to Oversight

Existing program integrity analyses have demonstrated the potential value of examining indicators such as unusually high utilization, overlapping services, significant deviations from comparable providers, missing EVV information, and recurring documentation concerns.

Iowa Medicaid should explore additional opportunities to consistently use data to identify services, providers, and billing patterns that may warrant additional review.

Medicaid could evaluate whether common risk indicators across fee-for-service and managed care would allow the state and MCOs to better target oversight resources toward areas presenting the greatest potential risk.

Any such approach should recognize that an unusual billing or utilization pattern does not necessarily indicate inappropriate activity. Members with significant disabilities, medical complexity, or behavioral health needs may appropriately require intensive services. Risk indicators should inform additional review rather than independently determine coverage, payment, or fraud.

2. Assess Opportunities to Strengthen EVV

Medicaid's review of EVV data has identified opportunities related to manual entries, data quality, governance, and the connection between EVV information and Medicaid claims.

Iowa Medicaid should continue evaluating opportunities to strengthen the quality and usefulness of EVV data.

Potential areas for further exploration include:

- reasonable expectations for electronic versus manual visit verification;
- improvements to EVV data fields and claim-level linkage;
- consistent processes for identifying and reviewing EVV anomalies;
- greater integration of EVV information with program integrity analytics; and
- whether EVV could provide meaningful program integrity value for additional high-risk HCBS services.

Before expanding EVV requirements, Medicaid should consider the nature of the service, administrative burden on providers, technological feasibility, member access, provider workforce impacts, and whether EVV would meaningfully improve verification of service delivery.

3. Explore Greater Consistency Across Fee-for-Service and Managed Care

Iowa Medicaid should explore whether greater standardization of program integrity review practices across fee-for-service and managed care would improve oversight.

The Applied Behavioral Analysis (“ABA”) work currently underway provides one potential model. Medicaid is exploring a standardized audit approach intended to promote greater consistency in compliance reviews across payment and delivery systems.

Medicaid could consider whether similar approaches would be beneficial for other services identified as presenting elevated program integrity risk.

Areas for consideration could include common audit criteria, documentation expectations, risk indicators, escalation processes, and methods for communicating findings across Medicaid and the MCOs.

Greater consistency could help Medicaid identify statewide trends while reducing differences in how similar circumstances are evaluated across Iowa’s Medicaid program.

Next Steps

Iowa Medicaid should continue its existing program integrity work while evaluating whether additional statewide strategies would improve quality, consistency, and accountability.

Areas for continued evaluation should include:

1. Risk-based identification and review of high-risk Medicaid services;
2. EVV data quality, governance, and appropriate use;

3. Opportunities for greater consistency between fee-for-service and managed care oversight

Chapter 4: Technology and Data Analytics

Recommendation 1: Allow recovered dollars to continue funding Medicaid services

Current Funding Flows

Two existing paths return program integrity dollars to Medical Assistance:

Medicaid Fraud Fund: Managed by the Department of Inspections, Appeals, and Licensing (DIAL) under Iowa Code § 249A.50. It receives penalties from Medicaid fraud prosecutions, investigative costs recovered by the Medicaid Fraud Control Unit (MFCU), and funds from compliance actions and audits. The DIAL MFCU recovers some of these dollars directly and the Attorney General collects others. Revenues average about \$150,000 annually, and the entire balance is appropriated to the Medicaid program.

Program Integrity recoveries: Overpayments identified by HHS Medicaid Program Integrity are credited to the Medical Assistance appropriation, directly offsetting expenditures.

Funding for Program Integrity Technology

HHS IT Fund

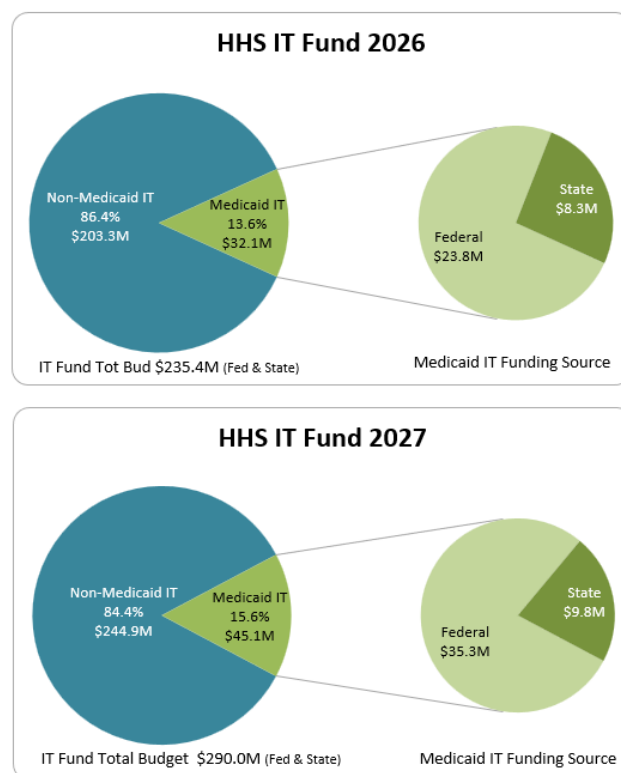
The HHS IT Fund was created in SFY26 through § 217.25. It is a state treasury fund managed by the Iowa HHS. Money deposited in the fund, however received, is automatically appropriated to HHS and limited to IT systems and modernization. The fund's accounting structure supports tracking and classifying IT initiatives. Medicaid IT expenditures are currently paid from the IT Fund.

The Gap

Program integrity technology has no category of its own in the IT Fund's current accounting structure, so its spending cannot be separated from other Medicaid IT or measured against the recoveries it helps generate.

Recommended Approach

1. HHS should add a Program Integrity Technology Unit within the IT Fund, recorded under Medicaid IT.



- It gives program integrity technology its own category and spending record, which does not exist today.
 - It is capitalized through the same budgeted Medical Assistance transfers that fund Medicaid IT today. Recoveries offset Medical Assistance program costs, so the unit draws on the budget that recoveries support.
2. Existing recovery continues to flow to Medical Assistance, unchanged.
 - Medicaid Fraud Fund dollars and program integrity recoveries continue to return to Medical Assistance, where the program allocates them where needed.
 - Protects Medicaid's resource allocations, allowing for maximization of federal financial participation.
 3. Route the unit's analytics and detection tools to HHS Medicaid Program Integrity.
 4. Track unit expenditures alongside recoveries to measure return on investment over time.
 - The IT Fund is automatically appropriated to HHS, limited to IT systems and modernization, and has an accounting structure that tracks initiatives.
 - No new fund or administrative layer is needed.

Figures 2 and 3 compare the current and proposed structures (under the current structure of MFCU under DIAL). New elements in green, dashed.

Current State:

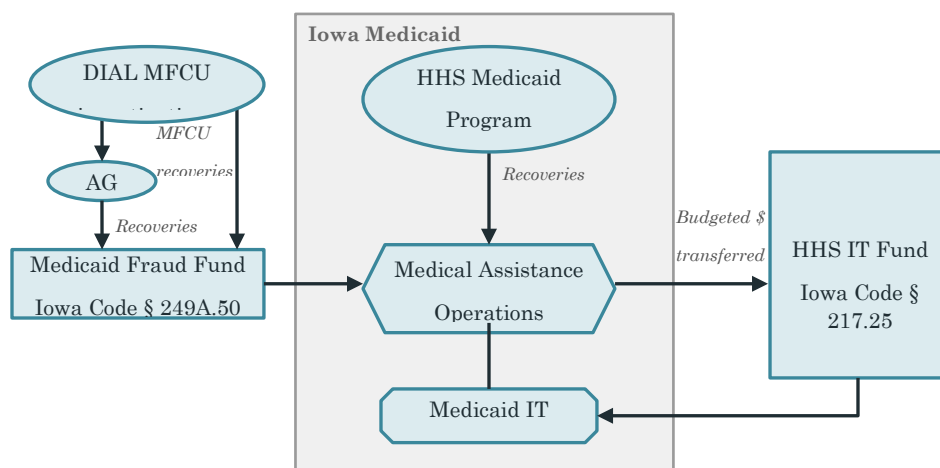


Figure 2. Current State: Medicaid Fraud Recoveries and IT Funding

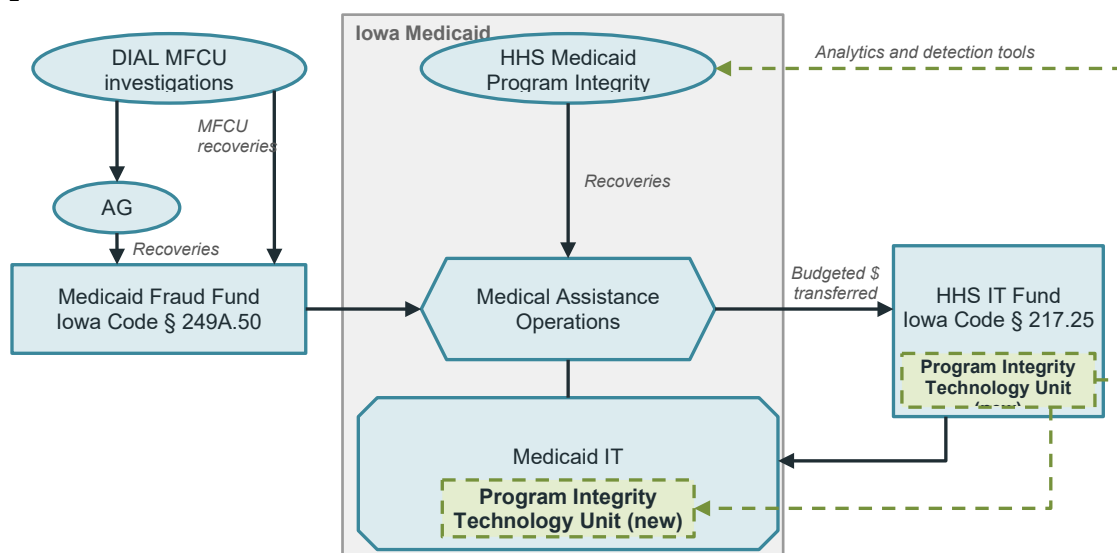
Proposed State:

Figure 3. Proposed State: Program Integrity Technology Unit within Medicaid IT

Recommendation 2: Iowa Medicaid should maximize advanced analytic capabilities.

Medicaid should continue strengthening member eligibility verification. Modernizing eligibility verification is essential for preventing improper payments and ensuring program integrity. Medicaid should continue integrating additional federal data sources, including the Social Security Death Master File, to complement state vital statistics and improve accuracy in identifying ineligible or deceased enrollees. Adoption of a national records-based analytics platform will enhance identity verification, risk scoring, and investigative workflows. Also, the current work to transition from a manual provider enrollment process to an electronic application will reduce errors, support automated checks, and close gaps that currently increase vulnerability to improper or fraudulent enrollment.

Iowa Medicaid should continue to expand data-driven methods to identify and act on high-risk fraud patterns. Regular analytic reviews of high-risk services have identified instances of outlier billing providers and patterns inconsistent with expected service thresholds. These findings highlight the value of automated analytics in detecting irregular utilization, documentation gaps, and unsupported service delivery. Audits underway across multiple service types demonstrate the need for structured analytic surveillance that can routinely flag unusual patterns, support managed care plans in oversight responsibilities, and guide targeted policy review. Creating both pre-pay and post-pay surveillance and incorporating these analyses into a systematic monitoring framework will allow the program to respond more

quickly to emerging risks and ensure that high-risk areas receive proportionate scrutiny.

Potential Next Steps

- Develop an Advanced Analytics and Modernization roadmap outlining goals, strategy, timelines, resource needs, stakeholder roles, and technology requirements for advanced analytics expansion and implementation of the recommendations outlined above.
- Provider enhancements to conduct more automated and proactive provider screening. This will improve provider experience, increase oversight capacity and strengthen threat detection over time.
- Adding EVV data to the Iowa Medicaid Data Warehouse to enhance analytic access to the data. This will allow for ongoing routine analysis to be automated, and data availability for ad hoc investigations.
- Data Verification Hub implementation to expand proactive member screening and verification.
- Formalize annual analytic review cycles for high-risk services and incorporate predictive modeling to identify emerging fraud patterns earlier.
- Expand managed care organization alignment to standardize data-quality expectations, reporting mechanisms, and escalation procedures to ensure a consistent statewide integrity approach.

Recommendation 3: Maximize HHS OIG data sharing partnership between Medicaid Program Integrity and MFCU.

Iowa Medicaid Program Integrity and the MFCU have a long-standing, highly collaborative partnership that has supported effective identification, investigation, and resolution of fraud, waste, and abuse. The recent federal changes allowing states to use federally funded Medicaid claims analytics without prior OIG approval creates a major opportunity to enhance this existing partnership. With broader and faster access to advanced OIG-supported analytic tools, Iowa Medicaid and MFCU can deepen coordination, accelerate detection of complex fraud schemes, and streamline investigative workflows. This expansion strengthens—not replaces—the strong joint foundation already in place, allowing both agencies to leverage federal capabilities more fully to protect the Medicaid program and its members.

Medicaid should explore bringing OIG-enabled analytic capabilities into existing joint workflows. With prior-approval requirements removed, Iowa Medicaid can rapidly deploy advanced analytic methods including pattern recognition, anomaly detection, and population-level analysis. Iowa Medicaid PI can work with MFCU to incorporate these enhanced outputs into shared operational routines such as monthly case review meetings, cross-agency collaboration activities, and ongoing surveillance. That

ensures that the partnership immediately benefits from richer, more timely insights without adding new administrative burden.

Medicaid PI and MFCU should formalize their shared risk indicators, prioritization criteria, and thresholds using the new analytic flexibility. This will support more consistent detection, reduce duplicative analysis, and create a more synchronized, statewide approach to identifying high-risk providers and service categories. The partnership already has a priority focus on high-risk areas, and enhanced OIG data access now allows the team to more proactively target emerging schemes and provider behaviors.

Medicaid and MFCU should consider enhancing collaborative investigations using OIG-supported analytics. The expanded access to federal analytic tools would allow MFCU to act earlier in the investigative cycle, particularly in complex or rapidly evolving cases. Faster identification of patterns will enable more timely referrals from the Iowa Medicaid Program Integrity team, and more comprehensive evidentiary documentation within the referrals shared. These enhancements will strengthen the partnership's ability to take coordinated civil and criminal actions when appropriate.

To ensure those changes translate into tangible benefits, Medicaid PI and MFCU should jointly outline how new capabilities will be used, how findings will be shared, and how expanded analytics will be incorporated into routine operations. This strategy should honor the existing partnership structure while identifying opportunities for improved efficiency, shared training, and consistent use of analytic outputs.

Next Steps

- Develop a joint implementation plan outlining how OIG's expanded data access will be operationalized in day-to-day PI and MFCU workflows.
- Identify priority analytic areas that would benefit most from immediate use of OIG-enabled data mining, such as emerging outlier behaviors or previously hard-to-detect patterns.
- Conduct shared training to ensure both teams understand how to interpret and apply new analytic tools and outputs effectively.
- Monitor impacts by tracking improvements in case referral quality, and early indicators of fraud scheme disruption.

Chapter 5: MCO Network Management

Recommendation 1: Encourage MCOs to adequately manage participation in their networks to ensure providers are legitimate entities billing for appropriate services to Medicaid members

Iowa Medicaid relies on a strong, engaged provider network to ensure members receive timely, high-quality care. While MCO credentialing processes confirm that providers meet qualifications, they do not always ensure that providers are serving Medicaid members. To maintain an accurate and functional network, Iowa should strengthen the systems that verify provider activity, validate network adequacy, and monitor real-world appointment access.

A component of the required annual network adequacy reports submitted by MCOs is a review of the sufficiency of provider networks and appointment availability. These reports are evaluated quarterly and annually to ensure compliance with access standards.

And Iowa Medicaid publishes performance dashboards and quarterly MCO reports, which highlight metrics such as provider panel status, encounter volumes, and access to care indicators.

MCOs also submit detailed encounter data that links each member encounter to a provider's NPI, taxonomy, and location. Iowa Medicaid analyzes these to confirm that actual patient care is being delivered; providers with low or nonexistent encounters are scrutinized.

Medicaid is currently revalidating all enrolled providers in phases, prioritizing high-risk providers. Non-responsive or inactive providers are deactivated, which ensures only active providers remain credentialed.

Opportunities for Improvement

Iowa Medicaid conducts annual and quarterly reviews of network adequacy reports submitted by MCOs, including provider availability and timeliness standards. Medicaid should explore enhancing automated cross-checks between directories and encounter data, standardized reporting cycles across the program, and expanded validation of appointment wait-time standards.

Encounter data is a critical indicator of whether credentialed providers are actually treating Medicaid members. Iowa Medicaid could consider developing analytic models to detect inactive providers, utilization gaps, and emerging access concerns.

Iowa Medicaid should explore reevaluating the frequency of secret shopper surveys, validation of online scheduling availability, and expand directory accuracy tools that

will improve transparency and ensure members receive accurate information about provider availability.

Iowa Medicaid Providers should be encouraged to adequately and accurately report network demographics to MCOs and Iowa Medicaid on a timely basis.

Recommendation 2: Continue strong partnership among Medicaid Program Integrity, MFCU, and Managed Care Organizations

Iowa Medicaid PI, the MFCU, and the MCOs have maintained a strong and collaborative partnership for many years. Since 2018, the joint MFCU/PI/MCO meetings have served as a consistent forum to discuss problematic providers, share emerging fraud trends, and align statewide program integrity strategies. Transitioning to a quarterly cadence in 2026 preserved the value of these meetings while ensuring they remain focused and efficient. These meetings continue to strengthen the quality of MCO referrals, support closer collaboration on credible cases, and provide shared training opportunities that improve alignment across the program.

Opportunities for Improvement

Quarterly meetings provide an effective venue for MCOs to receive direct guidance from MFCU and PI on referral expectations, documentation standards, and key fraud indicators. Medicaid should explore avenues to reinforce these expectations through discussion of real cases and statewide trends so the partnership can continue improving the accuracy, completeness, and timeliness of MCO referrals.

Medicaid should take an approach that strengthens collaborative case reviews to support earlier alignment on credible investigations. Joint case discussions allow PI, MCOs, and MFCU to evaluate concerns collectively, communicate determinations of credibility, and identify whether issues require further data development or immediate investigative action. This collaborative review process reduces duplication, ensures high-risk cases receive timely attention, and enhances coordination across all partners.

Iowa Medicaid and MCFU should consider enhancing training opportunities embedded within quarterly meetings. Trainings led by both MFCU and the Iowa Medicaid Program Integrity team helps ensure consistent understanding of fraud indicators, referral protocols, and regulatory requirements. Continued and expanded training opportunities will strengthen operational alignment and support more effective collaboration on case development.

The partners should maintain a streamlined meeting structure focused on meaningful collaboration. The quarterly MFCU/PI/MCO meeting structure should

continue prioritizing focused agendas, opportunities for partners to raise concerns, and dedicated time for training and case review.

Recommendation 3: Iowa Medicaid should increase its focus on oversight of managed care provider networks to ensure that providers are serving Medicaid members and thoughtfully evaluating risk for fraud, waste or abuse.

Network adequacy standards are intended to ensure that Medicaid members have timely access to covered healthcare services. Iowa Medicaid monitors the adequacy of provider networks maintained by Managed Care Plans (MCPs) through quarterly and annual reporting to the Centers for Medicare & Medicaid Services (CMS).

MCOs use extensive provider network management tools to enhance compliance with Iowa's contractual network adequacy standards and submit quarterly network adequacy reports and geographic access maps to Iowa Medicaid. Medicaid reviews these submissions for contractual compliance and submits an annual network adequacy report to CMS.

Iowa Medicaid has initiated a broader network adequacy review to establish a more accurate picture of provider availability across the state and identify data quality issues that may affect network adequacy assessments. One focus is identifying providers associated with unusually high numbers of locations that warrant further review to determine whether the reported locations reflect actual provider availability or potentially inflate network representation. High location counts do not necessarily indicate duplicate or inaccurate records, making validation important before drawing conclusions about actively serving members.

Although Iowa has established processes for monitoring network adequacy, opportunities exist to strengthen independent oversight, improve provider data quality, and modernize access standards.

Opportunities for Improvement

Current oversight relies heavily on manual reviews of large Excel files submitted by MCOs. A recent review identifies a need for routine data quality checks and validation rules to identify discrepancies in reported provider information. This approach can limit the efficiency and depth of independent validation.

Iowa Medicaid should consider strengthening its oversight processes by implementing more automated analytical tools, conducting targeted audits, and independently validating reported network information to confirm that listed providers are available to serve Medicaid members.

Accurate provider directory and network data are essential to evaluating access to care. The network adequacy initiative identified high provider location counts as an area requiring further review, along with inconsistent provider, location, and specialty information. An unusually high number of locations associated with a single provider may warrant validation to determine whether the information is accurate and whether each location represents meaningful access to care.

Providers listed in MCO networks may not be accepting new Medicaid members, seeing existing Medicaid members, or providing services at the locations reported. In addition, in-network providers may be missing from or hidden in public-facing MCO directories, limiting members' ability to identify available providers.

Potential improvements identified through the initiative include developing a centralized data quality dashboard to track trends and recurring issues, standardizing provider and location naming conventions across Iowa Medicaid and MCOs, and establishing uniform data submission requirements. Iowa Medicaid should also consider additional validation of provider location counts and more frequent confirmation of provider participation.

Iowa's network adequacy standards have not been updated since 2016. Reviewing and modernizing these standards would help ensure that requirements reflect current healthcare delivery practices, member needs, provider availability, and geographic access considerations.

Modernization should also consider whether existing measurement methods adequately distinguish between providers and locations reported in network files and providers and locations that are genuinely available to serve members.

Part of a recent network review done by Iowa Medicaid identified concerns about in-network providers missing from or hidden in MCO online directories. The initiative noted improvements to provider reporting, including adding a field to the reporting template to indicate whether providers appear in online directories, and identifies potential contract changes and directory audits to improve compliance.

Accurate provider directories are an important component of network adequacy oversight because members rely on these directories to locate care. Iowa Medicaid should continue strengthening requirements for directory accuracy, provider visibility, and consistent reporting across MCOs.

CMS requires states to establish and monitor network adequacy standards for Medicaid managed care. However, federal requirements provide flexibility in how network adequacy is measured and demonstrated. Iowa Medicaid can use this flexibility to strengthen independent validation, improve monitoring methods, and establish more meaningful measures of actual provider availability and member access.

Next Steps

- Develop an annual calendar of shared training topics aligned with emerging fraud trends and referral challenges.
- Document and distribute best practices for high-quality referral packages based on patterns observed in joint meetings.
- Track progress on collaborative cases discussed in quarterly meetings to identify successes and improvement opportunities.
- Regularly evaluate the quarterly meeting structure to ensure intentional agenda and objectives continue to meet evolving program integrity needs.