Overview

On April 1, 2016, the State of Iowa implemented a managed care program for the vast majority of Iowa’s 560,000 Medicaid beneficiaries. The program privatizes the state’s $4.2 billion Medicaid program, turning control over to three out-of-state insurance companies or managed care organizations (MCOs).

No other state has attempted to move its entire Medicaid program to a managed care model on such a condensed timeline. Unfortunately, lack of preparation time has resulted in a wave of disruption for Iowa Medicaid beneficiaries and health care providers alike.

Three months into implementation, data released by the state indicated that the MCOs experienced far higher-than-expected losses in the first quarter. At the same time, Medicaid beneficiaries continue to experience substantial restrictions in access to health care services and delays in receiving care, while health care providers are facing unprecedented new regulatory and administrative burdens, creating a sharp increase in unpaid or denied Medicaid claims.

Despite these challenges, Iowa hospitals have remained committed to serving the vulnerable Medicaid population. However, if hospitals are to maintain this commitment, the state must recognize the program’s flaws and seek immediate corrective action that puts Medicaid back on a course toward ensuring adequate access to health care services for Medicaid beneficiaries while providing fair and adequate reimbursement for hospitals serving Medicaid beneficiaries.

Position

IHA disagrees with the claims that managed care will lead to lower costs and improved patient outcomes because such results have not been achieved in other states. Instead, IHA maintains that provider-led initiatives such as the development of integrated health homes and Accountable Care Organizations (ACOs) hold more promise for cost and quality improvements. However, the reality of the program’s implementation dictates that the Legislature must respond to concerns from Medicaid beneficiaries and providers regarding the program’s growing regulatory and administrative burdens. Importantly, any proposal seeking to modify the Medicaid program must (1) expand access to crucial health care services for Iowa’s Medicaid population and (2) preserve or enhance provider reimbursement for services provided by Iowa’s community hospitals.

Action Needed

The Iowa General Assembly should pursue legislation to address the following concerns raised by Iowa’s hospital community:

Finance and Reimbursement

Provider Payment Rate Floors and Annual Updates

The Iowa Department of Human Services (DHS) has instituted “payment rate floors” for each provider that sets the starting point for payment rate negotiations between health care providers and MCOs. These payment rate floors were set at the same amount reimbursed to hospitals under the previous fee-for-
service payment system. However, these payment rate floors are not a matter of law or administrative rule and can therefore be changed at the discretion of DHS which places provider payment rates at further risk of reduction. The Legislature must act to codify provider rate floors to ensure that DHS cannot arbitrarily reduce provider payments as a means to meet program savings targets.

In addition, the Legislature should ensure that the provider rate floors are afforded an annual inflationary increase of at least 3 percent per year. Doing so will ensure that providers have the resources they need to remain sustainable, but also to offset losses that have already been sustained.

**Cost-Based Reimbursement for Critical Access Hospitals (CAHs)**

The transition to managed care has eliminated the cost-based reimbursement methodology which is vital for Iowa’s 82 small, rural Critical Access Hospitals (CAHs). CAHs rely on cost-based reimbursement because they are disproportionately impacted by their size and location and cost-based reimbursement allows them to remain financially viable in rural communities.

The Legislature should reinstate the cost-based reimbursement structure for these hospitals which includes the annual cost-settlement process that allows the state to review hospital cost data and calculate payment rate adjustments on an annual basis. Re-instating a cost-based reimbursement structure should not be viewed as a means to preclude CAHs from negotiating with MCOs, but rather allows more flexibility and fairness in the negotiating process for CAHs. Failure to reinstate this reimbursement methodology will lead to further instability in Iowa’s rural health care infrastructure which could result in reductions to health care services and access to care.

**Administrative Simplification**

**MCO Policy Standardization**

Medicaid beneficiaries should not be subject to different policies solely due to the MCO they’ve been assigned to or self-selected. However, each MCO has been allowed to develop its own unique policies across a wide variety of categories which is causing confusion among beneficiaries while significantly increasing the administrative load on providers. For example, under managed care providers must receive permission from MCOs to provide many services to patients. Unfortunately, all three MCOs have three different policies across all of the services that require this prior authorization. This adds time, complexity and cost to the health care system. The Legislature should direct DHS to mandate that the MCOs work together to establish uniform policies across the entire Medicaid program to reduce administrative complexity.

**General Policy Standardization**

Similar to the prior authorization issue, MCOs have been allowed to develop unique policies including: claims filing procedures, criteria used to approve or deny claims and a number of other variations that are leading to administrative complexity for providers and payment backlogs. The Legislature should require that all MCOs adopt standardized definitions and criteria and be required to follow the same processes modeled after the former process under fee-for-service.

**Program Oversight and Evaluation**

The Legislature passed modest oversight legislation in 2016 which lays out a good first step toward oversight of this program. However, the legislation doesn’t go far enough to ensure that providers and beneficiaries are protected from arbitrary reductions to payments or services, nor does it put in place evaluative measures that are needed to determine if the program’s objectives are being met.