In April 2016, the State of Iowa implemented commercial managed care for nearly all Iowans receiving Medicaid. While intended to contain costs and improve the quality of care, the initiative has not lived up to its promise. Significant financial and operational problems have raised serious concerns about both patient access to care and provider sustainability. With one of three commercial managed care organizations (MCOs) withdrawing from the market, these problems are likely to get worse (See “The Case for Change”). To avoid further losses, and do what's best to move Iowa forward, Iowa should pivot towards a Medicaid care delivery approach that improves data-driven care management at the site of care, eliminates administrative redundancy, promotes transparency, and moves the State to value-based payment arrangements that reward population health improvement.

**An Alternative Managed Medicaid Delivery System for Iowa**

Experience in other states and across payors has shown that improvement in care outcomes and efficiency are most likely to be achieved when built from the ground up – starting with engaging patients and providers at the site of care. IHA’s leadership assessed alternative service delivery and care management models for the Medicaid program, with a focus on value-based arrangements rooted in locally managed care with the goal of population health improvement. Building on the lessons learned in Colorado and Connecticut, two states that have transitioned from commercial managed care to provider-driven care management approaches, IHA developed a new model to support access to coordinated, high-quality health care services for Iowa’s Medicaid beneficiaries.

**The Case for Change**

**State Cost Containment and Care Management Goals Have Not Been Advanced**

- Three MCOs each lost more than $100 million in their first year, requiring the State to offset losses and significantly diminishing any State fiscal gains.
- AmeriHealth’s withdrawal from Medicaid requires the transition of 214,000 Iowans to the two other plans, including more than 23,000 long-term care enrollees, potentially disrupting patient-provider relationships. Procurement of a new MCO will require further transitions and result in additional disruption.
- MCOs are not meeting the needs of complex, high-cost populations. Complaints regarding long-term care access have surged, and the State lacks meaningful approaches for managing long-term care or coordinating community-based behavioral health options.

**Administrative Complexities and Inefficiencies are Burdening Providers**

- Disparate administrative practices across plans (e.g., utilization management) and delays in payment have placed significant strain on providers.
- Claim denials are as high as 15% in some hospitals and accounts receivable have increased substantially (e.g., $400,000 in a single quarter).
- Lack of transparency from MCOs, particularly regarding clinical data and rate-setting, has undermined accountability and made it impossible to assess program performance.

**Financial Sustainability of Hospitals in Underserved Communities is Being Threatened**

- The elimination of cost-based reimbursement for Iowa’s 82 critical access hospitals (CAHs) has put their future survival at risk.
Core features of the model include:

1) Statewide Administrative Services Organization (ASO)
A statewide ASO would provide Iowa with a more efficient and rational approach to managing medical and behavioral health services. The primary function of the ASO would be to focus on statewide population health improvement. Rather than delegating this responsibility to multiple plans, each with their own priorities and proprietary care management systems, the ASO would develop targeted statewide performance goals and a coordinated infrastructure to support providers in achieving those goals. The ASO, in collaboration with Iowa hospitals, physicians, and others, would be responsible for supporting care coordination through the deployment of care managers, and serve as a unified administrative backbone and accelerator for provider-led initiatives to advance care management, practice transformation, and value-based payment objectives. A single statewide data analytics infrastructure, managed by the State (or its contractor), would undergird this effort, supporting information exchange among providers, data analytics for the ASO to inform population health management efforts, and transparent external reporting to State regulators and stakeholders.

The statewide ASO also would be responsible for administrative responsibilities, including developing and maintaining networks of providers to ensure appropriate access to care. A costly disadvantage of Iowa’s current commercial managed care system is the fragmentation and duplication of administrative costs for providers, plans, and ultimately the State. MCOs each build and maintain their own systems and processes for credentialing and enrolling providers, reviewing and paying claims, sharing and reporting data, managing patient care, and other functions. Iowa currently pays a 12% administrative load to MCOs for these functions; additional costs are incurred by hospitals, physicians and other Iowa health care providers responding to varying and duplicative MCO demands. The ASO would receive monthly administrative payments targeted below the average administrative spend under the current MCO model, with a percentage of payment contingent on meeting performance metrics defined by the State.

The ASO model has demonstrated success in Connecticut, improving quality, streamlining administrative processes, and reducing overall administrative costs to 5% compared to 12% under commercial managed care. Colorado established analogous coordinating entities, known as Regional Care Collaborative Organizations (RCCOs), which also have achieved improvements in care quality and cost savings.
2) **Provider-Led Care Management Initiatives**

Iowa’s current commercial managed care system delegates full responsibility for managing patient care to two commercial MCOs. These plans have variable care management approaches and capabilities that, when filtered down to the site of care, have little to no impact on the way providers interact with patients. Iowa should rationalize and focus its care management by directly engaging Iowa’s Medicaid providers, in collaboration with consumers and other stakeholders, in developing and implementing standardized quality measures, clinical guidelines, and care improvement initiatives. Under this proposal, providers would leverage the ASO’s centralized resources (e.g., data analytics, care managers, social workers) to design and implement provider-led strategic initiatives in partnership with other providers across the continuum of care (e.g., dental, social service providers) that take into account the diverse needs of Iowa’s communities, including rural settings. Many of these initiatives will initially focus on primary care and behavioral health, expanding over time to address other key priorities in the State, such as long-term care.

Provider-led care improvement initiatives have seen success in Colorado and Connecticut where they have advanced improvements across key quality indicators (e.g., reduced ED visits, improved access to preventive care). While the role of hospitals in both states has been limited, Colorado is pursuing a Medicaid waiver to elevate the hospital role in care coordination. IHA envisions that Iowa hospitals, physicians and other providers will work with the ASO in the planning and deployment of initiatives that span the care continuum and include hospital-based interventions.

3) **Incentives for Care Management and Quality Improvement and a Roadmap for Value-Based Payment**

Commercial managed care in Iowa has failed to advance Iowa’s cost containment goals, requiring the State to offset more than $300 million in MCO losses in their first year of operation. Further, the transition to managed care has threatened the financial viability of providers and inhibited, rather than supported, their ability to pursue value-based payment models. To achieve maximum value for its Medicaid dollar, Iowa must encourage and support payment models that bring incentives and accountability closer to the site of care. To address these issues, we propose developing a statewide roadmap for adoption and advancement of value-based payment models, which takes into account the diversity in provider readiness across the state. Building upon a fee-for-service reimbursement foundation for medical and behavioral health services – including a uniform fee schedule, annual reimbursement updates, and cost-based reimbursement for CAHs – the roadmap would transition appropriate providers to value-based payment arrangements over time.

In the early phases of roll out, providers would be eligible to receive incentive payments for enhanced care management and quality improvement activities, with payments increasingly tied to outcomes over time, including potentially primary care sub-capitation and even full/global capitation models, where appropriate. Special accommodation will be made for small and rural providers to ensure the roadmap is responsive to their capabilities and the needs of their communities. This approach has been tested successfully in Colorado and Connecticut, where providers receive fee-for-service reimbursement for clinical services, as well as incentive payments for specific activities (e.g., PCMH certification, care management). The value-based payment roadmap will help shore up the financial
viability of Iowa’s Medicaid providers, while positioning the state for advancing risk-based payment models in the future.

4) **Enhanced State Oversight and Accountability**
MCOs have not been transparent, nor held accountable, under the current managed care structure. The proposed ASO structure is designed to address this issue by promoting greater transparency through data sharing and increasing the State’s role in providing direction and oversight of Medicaid program operations. In both Colorado and Connecticut, the Medicaid agencies play a significant role in overseeing program activities, including generating regular reports on program performance and outcomes. A greater role for the State in Iowa will likely require investment in organizational capacity and infrastructure within the Department of Human Services, and necessitate regular engagement with the Legislature and other State agencies and stakeholders to ensure accountability and responsiveness to the needs of Medicaid beneficiaries and providers.

★ **Next Steps**
Over the coming months, IHA will engage with the Department of Human Services, the Legislature, health care providers, consumer advocates and other key stakeholders to test and refine the model. IHA seeks to bring forward a workable alternative to the costly and broken commercial Medicaid managed care system, one which will contain costs and advance the quality of care delivered to Iowa’s Medicaid beneficiaries.