Medicaid: Easing Administrative Burdens for Iowa Providers

2020

IOWA HOSPITAL ASSOCIATION

We care about Iowa's health

Many hospitals and Medicaid members struggle with the administrative complexities resulting from the introduction of Medicaid managed care companies in Iowa. The changes in companies administering the program, including the recent departure of UnitedHealthcare and the addition of Iowa Total Care, keep hospitals and other providers in a transition of learning how to navigate policies for reimbursement, prior authorizations, credentialing and appeals without positive effect on outcomes from the disparate policies.

The Legislature should support legislation such as SSB1234, which takes steps to create consistent policies to ease the administrative burden for providers, specifically with reimbursements, prior authorizations, credentialing and appeals.

Issue Background - Talking Points

- In April 2016, Iowa started commercial managed care for nearly all Iowans receiving Medicaid.
- Iowa's Medicaid program serves 24.9% of the state's population.[1]
- For fiscal year 2020, the Legislature appropriated more than $1.7 billion to fund the Medicaid program.[2] With the federal match for Medicaid funding, the program affects $5.8 billion in public funding.
- The commercial managed care system for Medicaid has had several significant changes since its implementation, including onboarding a new managed care organization and the transition for Medicaid members from two organizations that have withdrawn from Iowa's program.
- Reporting on program goals and requirements is provided by the managed care organizations.[3]

Recent Policy Changes

- The Legislature in 2019 in HF 766, Division XVI, mandated the Department of Human Services to adopt rules by Oct. 1 to require a uniform process for prior authorizations. To date, no rules have been noticed.
- The Legislature also mandated the department to investigate the costs of expanding the medical assistance management information system to integrate a single, statewide system to serve as a central portal for submission of all medical prior-authorization requests for the Medicaid program. The results of the study are due March 31, 2020.
- Medicaid policy is most successful when members can choose their Medicaid providers. Policies should be implemented that encourage providers to remain in the program by reducing unnecessary complexities for prior authorizations and timely credentialing, and fair, accurate and timely reimbursement.

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Legislative Request

- Promoting greater transparency through and increasing the State's role in providing direction and oversight of Medicaid program operations will enhance Medicaid's effectiveness and reduce unnecessary administrative costs.
- Providing streamlined processes and oversight under the Medicaid program allows for greater transparency in a program that relies on $5.8 billion in public funding.
- Consistency in Medicaid processes and procedures with prior authorization requirements; uniform payment authorization criteria and timely payment; posting accurate rosters of participating providers; and submission and tracking of claims, claims disputes, claims reconsiderations and appeals on the Medicaid managed care organization's website will help eliminate much of the administrative costs of health care providers and help address the financial impacts, particularly to rural hospitals.
- Using a single credentialing verification organization for credentialing and recredentialing providers with the Medicaid managed care and fee-for-service payment and delivery systems will help reduce delays in getting providers in the system and enhance the member's experience.
- Enhancing the internal and external review processes for Medicaid providers for the review of initial and final adverse determinations of the MCOs' internal appeal processes also will bring more transparency to the system and ensure decisions are made using appropriate medical criteria.
- Ensuring uniformity in processes and appeals by outside parties enables greater transparency and better member outcomes for this vital program that touches a quarter of Iowans.

The Legislature should ensure the Medicaid program, which is appropriately using resources to provide appropriate and necessary medical care to Medicaid beneficiaries while ensuring unnecessary administrative costs and processes are eliminated for the most efficient and value-based care.

1. Iowa Medicaid Enterprises, Improve Iowans Health Status, accessed at https://dhs.iowa.gov/sites/default/files/3_Improve_Iowans_Health_Status_3.pdf?090920191916
2. HF 766; https://www.legis.iowa.gov/docs/publications/EOS/1046098.pdf
3. The Department validates the data by looking at available fee-for-service historical baselines, encounter data, and by reviewing the source data provided by the MCOs. Iowa Medicaid Enterprises, Managed Care Organization Report: SFY 2019, Quarter 3 (January-March) Performance Data, June 14, 2019, page 2, accessed at https://dhs.iowa.gov/sites/default/files/SFY19_Q3_Report.pdf?070220191710