FISCAL TOPICS
Fiscal Services Division
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Managed Care Organizations

Summary
Medicaid is a jointly funded State and federal program that provides health and long-term care coverage to low-income and disabled Iowans. Managed Care Organizations (MCOs) provide health care coverage to Iowa Medicaid enrollees from their network of providers across the state in return for a set per member per month (PMPM) payment rate from the Iowa Department of Health and Human Services (HHS). As of July 1, 2024, Iowa Medicaid is administered by the HHS and three MCOs: Iowa Total Care, Molina Healthcare of Iowa, and Wellpoint Iowa (formerly Amerigroup Iowa, Inc.). In addition, there are two MCOs that administer the Medicaid dental program: Delta Dental and MCNA Dental.

Background
MCOs are integrated entities in the health care system that aim to reduce health care costs. Since the 1970s, MCOs have altered health care delivery in the U.S. through preventative medicine strategies, financial provisioning, and treatment guidelines. MCOs implement policies for health care providers as a cost-saving method, including the creation of provider networks, medication protocols, utilization management, and financial incentives that influence how and where a patient receives medical care.

In 2016, Iowa Medicaid implemented an MCO model by transitioning more than 90.0% of its Medicaid population from a traditional fee-for-service (FFS) model to three MCOs: AmeriHealth Caritas, Amerigroup, and UnitedHealthcare. This change created new procedures for health care providers by implementing prior authorizations and a claim review process overseen by the MCOs. In 2017, AmeriHealth Caritas terminated its contract, leaving Iowa with two MCOs, while UnitedHealthcare left the Iowa Medicaid market in 2019, replaced by Iowa Total Care. Since 2017, only two MCOs had Iowa Medicaid contracts until Molina Healthcare of Iowa was under contract beginning July 1, 2023.

Medicaid members have an initial choice of MCOs, which act as insurance companies, during what is called a Member Choice Period. Outside of the Member Choice Period, current enrollees in an MCO will be able to change their MCO during the next annual period or for specific reasons. Medicaid members work directly with the MCO and their providers on health matters, except during enrollment and re-enrollment periods when the HHS has administrative protocols that prospective members must adhere to. Members with specific and uncommon needs may also be assigned to the HHS, which continues to operate Medicaid as an FFS model for less than 10.0% of the member population.

MCOs receive a set capitation rate PMPM from State and federal Medicaid appropriations, depending on the age, gender, and program of a member. For instance, a young child, who has relatively fewer health care needs, is assigned a lower monthly rate of payment to the MCO, while an elderly member in a residential care facility is assigned a higher monthly rate due to the high costs of nursing care. In FY 2024, there were 46 capitation rates paid by the State to MCOs. Within PMPM total payments, the MCOs are responsible for administering payments to health care providers based on services and patient needs. The MCOs are contractually allowed to use a small percentage of capitation rate payments for administrative purposes, while using a large percentage of capitation rate payments for health care and member services.

More Information

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Annual capitation rate payments are negotiated between the HHS and MCOs and are based on prospective MCO costs for member services, while a small percentage of MCO costs are fixed costs that may be paid by the State. Higher Medicaid enrollment will increase State payments to the MCOs based on PMPM capitation rates. Health care providers are paid a rate for Medicaid services based on available State and federal appropriations. Any increase in State appropriations for Medicaid provider rates creates an increase in rates paid by the MCOs to providers for Medicaid services.

Expenditures
State Medicaid expenditures paid from the HHS to the MCOs since FY 2019 are summarized below. State revenue comes primarily from the General Fund appropriation to the HHS for Medical Assistance (Medicaid); however, revenue streams from other funds, including the Health Care Trust Fund, Nursing Facility Quality Assurance Fund, Hospital Trust Fund, and Medicaid Fraud Fund, are appropriated to the HHS for Medicaid and are also used to pay MCOs.

- FY 2019 = $1.528 billion
- FY 2020 = $1.604 billion
- FY 2021 = $1.558 billion
- FY 2022 = $1.561 billion
- FY 2023 = $1.624 billion

Iowa Related Statutes and Administrative Code
Iowa Code chapter 249A
Iowa Administrative Code 441—73

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