

2016 Medicaid Managed Care Principles



★ Overview

The State of Iowa is pursuing a managed care program for the vast majority of Iowa's 560,000 Medicaid beneficiaries. Managed care will "privatize" the state's Medicaid program and transition its administration to private, for-profit insurance entities referred to as managed care organizations (MCOs). This proposal fundamentally changes the way in which the Medicaid program functions along with how beneficiaries and providers interact with the program.

IHA is supportive of truly innovative transformation within the Medicaid program that seeks to bring about expanded access to health care services for Iowa's Medicaid population while preserving adequate payment for those services provided by Iowa's community hospitals. IHA has proven this support through engagement and investment in programs like the Iowa Health and Wellness Plan and in the State Innovation Model (SIM) grant process, both of which seek to reduce health care costs and improve quality through the use of new delivery and finance models like Accountable Care Organizations, for example.

★ Position

Unfortunately, the state's Medicaid managed care proposal does not recognize the tremendous progress that has been made in recent years regarding the successful development and deployment of innovative programs that seek to reduce health care cost and improve quality. Rather, the plan lays out a "status quo" capitated payment system that puts in place strategies focused on reducing access to care and ratcheting down reimbursement to providers as a means to generate budget savings for the state.

Therefore, given past experience in Iowa with national MCOs and lessons learned from managed care in other states, **IHA opposes the state's initiative to implement managed care** and remains deeply concerned about the impact it would have on access to care for Medicaid beneficiaries, reimbursement for care to providers (within an already complex and evolving payment and delivery system) and alignment with Accountable Care Organizations already functioning through the Iowa Health and Wellness Plan and SIM.

However, should the state proceed with this transition, the following principles must be considered to preserve access to vital health care services for beneficiaries and adequate reimbursement for providers.

★ Guiding Principles

- **Procurement and Implementation Timeline:** The proposed transition to managed care represents a significant shift in Iowa's health care delivery system and proposes to place Iowa among only a very few states that include virtually 100 percent of their Medicaid populations in managed care.

The timeline is far too aggressive, unrealistic and increases the potential for unintended consequences. Rushing this process will result in unnecessary patient and provider confusion, claims denials, restricted access to care and potential litigation. The state should slow down, phase-in implementation and provide answers to critical questions before moving forward with implementation.

- **Cost-Based Reimbursement for Critical Access Hospitals (CAHs) and other providers:** The proposals have not been specific regarding reimbursement for CAHs and other providers that

receive cost-based reimbursement (home health agencies, community mental health centers, rural health clinics, etc.), as under a managed care environment rates are negotiated between providers and contractors.

Cost-based reimbursement for CAHs and others must continue under managed care. Hundreds of providers across the state rely on this reimbursement methodology as a means to remain financially viable and provide access to health care services for Medicaid beneficiaries in rural areas. MCOs should include a cost settlement process in their CAH reimbursement methodologies and contracts.

- **Retroactive Enrollment and Provider Reimbursement:** The waivers are seeking an exemption to what is known as “retroactive enrollment”. Currently, providers can be reimbursed for care provided (within 90 days following the visit) to individuals who qualify for Medicaid but are not yet enrolled.

Retroactive enrollment is standard policy under the Medicaid program and should be continued to ensure appropriate access to coverage and timely provider payments under managed care. Failure to do so will shift the cost of care to hospitals that provide care to individuals who ultimately become enrolled in Medicaid.

- **Provider Credentialing:** IHA and member hospitals are concerned about the timeline and feasibility to ensure all providers are adequately credentialed with the MCOs prior to the start of the program. Other states’ experience has shown that large credentialing backlogs occur, resulting in denied claims and an increase in charity care and bad debt for providers.

The Iowa Medicaid Enterprise has indicated that it will not automatically credential providers. IHA believes that, at a minimum, credentialing standards should be consistent across all MCOs. Additionally, all MCOs should be required to offer “deemed” credentialing whereby the hospital can engage in credentialing of all hospital-employed physicians and clinical staff.

- **Claims Processing:** Millions of claims will be processed by the MCOs on an annual basis. Today, providers submit all claims to a single entity. Under managed care, providers could be faced with four separate claims processing systems leading to administrative complexity and reimbursement backlogs.

To process claims in the most efficient and effective manner, MCOs should be required to accept a standardized claim form, follow identical claims processing procedures and adopt common definitions (clean claims, timely filing, etc.).

- **Timely Filing:** To incent efficiency in claims submission and reimbursement, providers and payors agree to a timely filing window. The state has proposed a 90-day timely filing deadline under managed care. However, the current timely filing deadline under Medicaid (which is also consistent with other commercial payors like Wellmark Blue Cross and Blue Shield) is 365 days for clean claims¹.

¹ IV. BILLING IOWA MEDICAID <http://dhs.iowa.gov/sites/default/files/All-IV.pdf>

IHA supports continuing the 365-day timely filing timeline to ensure providers have enough time and flexibility to sufficiently document, code and submit claims.

- **Claims Denials and Provider Appeals:** Similar to the claims processing issues, each MCO will also have its own definitions and criteria regarding medical necessity and claims denials procedures. This will lead to administrative complexity for providers and could lead to payment backlogs.

All MCOS should be required to adopt standardized definitions and criteria regarding claims denials and should follow the same process regarding appeals, modeled after the existing process under Medicaid today.

- **Provider Network Development:** There is not enough time for the state and other interested parties to review contracts and ensure that the MCOs have released necessary administrative information (provider manuals, etc.), credentialed providers and have claims processing and all required operational infrastructure in place under the current timeline.

IHA opposes any policy that would require a hospital to enter into a contract arrangement with an MCO or other entity prior to the waivers' approval.