Medical Group Management Association
Iowa

Iowa Medical Group Management Association
Report of Concerns to the Health Policy Oversight Committee
regarding Medicaid Managed Care Transition
November 3, 2015

Iowa Medical Group Management Association (IMGMA) has concerns over the recent changes to an already aggressive role out of the Medicaid Managed Care. Deadlines are set that are at best pushed to the extreme with providers having access to very little information and communication. IMGMA is not here to argue the privatization of Medicaid – that decision has been made. But as our members try to properly prepare for the transition the timeline imposed is creating an undue hardship on the providers and their patients.

The primary part of providing healthcare care is between the patient and the provider. However due to economics there are three parts to providing care to this population; the patients, the providers, and then the payors (State of Iowa and its contracted carriers). Three legs are needed to make this stool stand up, but this transition plan will weaken two legs – Patient and Provider relationship.

The state has repeatedly indicated that to help in the very aggressive transition, the managed care organizations (MCOs) are prohibited from "restricting" patients' ability to see their existing Medicaid providers. Then on July 1, 2016 the MCOs would be able to close their networks. Up to recently, the state has implied that during this open-network period, providers who were not contracted with an individual MCO would still receive 100% of current Medicaid rates, though maybe they would need to execute some sort of single-use agreements or short-term contracts with the four MCOs who will be the sole entities paying managed care claims starting January 1, 2016. The state has now reversed course on this planned policy. Under "policy clarification" that state staff have begun sharing verbally and plan to push out in written form soon, starting January 1, 2016, MCOs are still required to allow patients to see any existing Medicaid provider for the first six months of the program. However, the MCOs will be allowed to treat those providers who have not contracted with them as out-of-network for the purposes of reimbursement. They are allowing these MCOs the ability to pay out of network providers only 90% of the once promised floor fee for service payment floor.

It is the IMGMA belief that the contract information provided has been incomplete at best and we have reports from member clinics in the state substantiating that concern. Some IMGMA members are still waiting for a contract to review. Members have indicated they have started negotiations but are finding the negotiations slow, not due to the member but from the payor. Some members have indicated that they are having difficulty in getting a response from payors to even start negotiations. One member wrote that they had questions about the contract – they looked on the web site – the web site instructed them to call the call center – they called to call center to be referred to the website, which they informed them they had – so then were elevated to a supervisor who couldn't answer their questions.

It is the IMGMA belief that by allowing MCOs to institute a 10% penalty for out of network services, MCOs are being rewarded in slowing down or restricting the contracting process while all at the provider's expense. All during this time it has been out of the providers' control contracting and then leading into the time consuming process of credentialing.

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Please understand Medicaid reimbursement to Medical Groups is low in the first place. Many providers understand their responsibility to the community and participate with Medicaid to allow these people access to healthcare. Providing an additional payment penalty to providers who already dedicate a significant portion of their daily schedule to treat at a lower cost seems counter intuitive. So it appears the logic is to punish the provider who chooses to maintain the patient/provider continuity of care until the transition takes place?

In September state wide informational meetings we scheduled. IMGMA members were ready to obtain critical information and arranged for their key staff members to attend the organized forums to get details directly from the MCOs. But the information was at best generic and most of the talking direct from the IME with absolute no specifics from the MCOs in attendance.

Now that some decisions have been made between the State of Iowa and the MCOs, and the State of Iowa has reviewed the MCO policies and procedures, why isn't there the effort to organize statewide meetings so providers can now get answers to the questions they had back in September?

The delays in the process are not due to IMGMA members. The ability for the provider to use due diligence in reviewing the contract before signing is being severely compromised without providing a transition period without penalty to the provider. We have had several larger members note that the administrative task of credentialing will be impossible for some to complete in time.

Summary, the state's policy shift for the initial open-network period will have significant implications for practices and possibly for their patients. If practices have not contracted with MCOs by January 1, 2016, they will be subject to a 10% rate cut for the care they provide to Medicaid patients. **How is a 10% payment penalty in a transition period not viewed as a restriction of a patients' ability to see their providers? Please go back to the original transition period and allow providers proper due diligence in reviewing payor performance and the respective contracts to allow for a successful long range implementation.**

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