I was very honored to be asked to share Iowa’s experience with the implementation of Managed Care with a National audience at this year’s Public Health Law Conference. Of course, this story continues to unfold as we all work toward better health outcomes across Iowa and in this particular population. Some of the details included have changed since September 2016. This presentation represents a point in time.
A mid-western state of 3.2 million
Rural with a few larger metro areas
Traditional Medicaid and its programs have been viewed as moderately successful in maintaining the health of those enrolled and in meeting the needs of those involved in their care.
Within this system, Managed Care products included: Medipass, HMO, Iowa Health and Wellness Plan, Dental Wellness Plan, Iowa Plan, Non-Emergency Medical Transportation, and the Program for All Inclusive Care for the Elderly (PACE).

HCBS Waiver programs included 7 areas: Physical Disabilities (PD); Health and Disability (HD); Children's Mental Health (CMH); Elderly; Intellectual Disabilities (ID); AIDS/HIV; Brain Injury (BI)
An announcement was made that there would be a transition of traditional Medicaid and the RFP was released in February 2015, amid some concerns across providers including public health leaders. There was a general belief that what we had was working and the increased expenditures were more likely due to the increase in the number of people who qualified for Medicaid based on their income vs. overuse or inappropriate use of the services and waste, fraud, or abuse.

There was one awardee whose contract was overturned in December 2015, leaving 3 remaining MCO’s: Amerigroup, Amerihealth Caritas, and United Healthcare.

CMS conducted overwhelmingly attended listening sessions with stakeholders throughout December 2015, resulting in an extended start date of April 1, 2016. Medicaid held a series of public meetings across the state to gather input from and educate stakeholders. Information provided to members and providers was slow, incomplete, and delivered in a manner that was confusing and often grey in content. The thought of attending to the needs of members and explaining their coverage and their necessary actions was an overwhelming thought. Most public health agencies did not have the capacity to deliver this much needed information in 1:1 interactions.
Fears experienced when the RFP was released mounted as the launch date neared. There was little consistency across awardees, there were questions about coverage, and the transfer of programs and projects from traditional Medicaid to the MCO’s was limited in scope and vague in presentation, and the bodies of providers began to conduct their own specialized meetings with the intention of educating the leaders of those organizations about the importance of maintaining what was working for members and their caregivers.

Title V Maternal and Child Health service providers, Waiver providers, Home Health providers, hospitals, and physician clinics were just a few of the groups who had special interest in speaking with MCO leadership about their concerns.

Many conversations were related to reimbursement but other conversations more broadly addressed the needs of the members and the importance of their ability to maintain their coverage and their care. There was agreement that if Managed Care did not work for members, it would not work for providers.
These were the main milestones in implementation according to public health leaders.

MCO’s used mailing to educate their members about their programs, to advise them of their enrollment, and articulate their power to modify their assignment. Many had questions about their benefits and what the change meant. We advised those who were able to attend community meetings, and as you can guess, many felt powerless and voiceless. Members also experienced a great deal of fear. Caregivers of children with special healthcare needs, CDAC (Consumer Driven Attendant Care) providers, and those receiving specialized care in neighboring states had many questions with few answers.

I want to make a special mention of this fact: The Iowa Department of Public Health was not invited to the planning table when the implementation plan was being created and they had no input into the MCO contracts. This represents a limited ability of the MCO’s to work toward something near and dear to our hearts: intervening at the level of the social determinants of health. Their Value Added services begin to move in that direction but input from local public health agencies is needed to leverage MCO’s to provide support for primary prevention within Iowa’s
communities. They are interested, but their contracts limit their interaction as they are currently written. Some of the awardees have initiatives in other states that are not being replicated in Iowa due to this deficit.

Contracts were released in the Fall of 2015. Many public health agencies signed with all three immediately but there were also those who didn’t sign any of the contracts right away. There were questions about what agencies would be paid, how they would be paid, what their legal rights were surrounding the language of the contracts were, and again…. Fear. Choices were limited and attempts at modifying contracts were met with resistance and lack of cooperation. To qualify this, in hindsight, the MCO’s were not provided enough information from Iowa Medicaid to make good, solid decisions based on Iowa’s model. Decisions were and still are made with information managers have from their experiences in other implementation states.

In my agency’s experience, credentialing followed the contract execution, which occurred into the Spring of 2016: 5-6 months after we submitted our records. Changes in address, shared Tax ID numbers among County entities, and contracts with other products associated with these companies further complicated the process. Many errors are still occurring, especially with regard to billing and payment.

Questions surrounding billing and payment were the following: Will we need 3 different types of software? What is the cost? Will there be training? Will there be technical assistance? Answers were slow and came well into April, just prior to the first billing of services after implementation. Submitting clean claims, coding, units billed, dual Medicare coverage and communicating homebound status for home health patients receiving both Waiver services and Medicaid Home Health Services, created many denials and continues to be a source of frustration for all parties.

Home health providers had not previously had to complete prior authorizations. There was little understanding by the MCO’s of how this worked and dual coverage and homebound status was challenged in the authorizations and in claims submission. Solutions are still being explored, and some progress is being made. Home health and homemaker aide services represent a major area of confusion: will payment be based on time spent or per unit, using revenue codes or units? More education is necessary. Advocacy organizations in Iowa for this provider type are currently holding bi-weekly calls to leverage increased communication, opportunities for education, and enhancements to services provided to members. Many authorizations require appeals and many appeals result in state fair hearings with IME. Authorizations were for 30 days / 9 visits max and now we are seeing an increase in those time frames. MCO’s have admitted that these authorizations are time intensive for their staff as well, and due to this, I expect more changes ahead.
Home health leaders have reminded MCO’s that they do not act on their own orders but are responsible for care under the order of a physician and must meet CMS guidelines and timeframes to maintain their licenses. Inquiries to the physician to ‘write a justification’ for these services is met with apathy and resistance and the impact is ultimately leveraged to the client.

Public health providers also questioned the MCO transportation services (NEMT). Previously, one provider existed and it didn’t work as well as we would have liked, so this is one area where we thought there would be substantial improvement. There are 3 separate providers: one for each MCO. I am not a transportation provider, but the word is that rides are still cumbersome to arrange and payment has been just as rocky as other provider types have experienced.
Asking my peers about their experience was the best way I knew to communicate to you what Iowa’s Public Health Managed Care Experience has been. My survey used questions from the Situation Assessment from Technology of Participation’s Approaches to Environmental Scanning Manual. This set of questions explores the past, present and future surrounding a situation with 6 factors as headings for creating the questions.

The following slides will showcase both the questions and the answers I received over 1 week from 60 providers in public health, transportation, home health, physical therapy, and other related services.
There was a great level of satisfaction with this system as it was easy to navigate and issues were solved, even though some issues took some time and energy solutions were still reached.

One stop shopping was tough to move away from.

Payment rates, member responsibilities, communication loops, and wellness-based care were some of the perks.

I do want to call out Iowa’s Title V MCH programs and their quest for maintaining a long-standing relationship with IME. The arrangement was that agencies were paid per 15 minute unit for coordinating care to Medicaid services (PCP, pharmacy, transportation, mental health, etc.) The contract was managed through the Title V program in a contract between that Bureau and IME.

Many meetings were held, and the conversations continue, but Title V provider reimbursement did suffer.
Did you have any issues with IME in the past? How did you resolve them? Were you satisfied with the results?

- Past practices were streamlined and efficient for easy resolutions and satisfaction.
- Rarely, phone call or email - quickly resolved. Very satisfied - didn't always like the answer but it was fair, consistent, and quick.
- Most of the time they were able to help resolve the problem. We were usually satisfied with the results.
- There are always some small issues that arise, but overall, no big issues on policy matters.

This question revealed more of the same types of responses as the previous question.
I previously discussed the milestones and these answers are in agreement with what was experienced. Time spent on authorizations is not accounted for within the payment rate and many agencies do not have the personnel or fiscal resources to address what they need to address in order to be paid.

Answers to questions from providers are varied among and within each MCO... the call for more education comes from both providers and members.

Each MCO has a steering committee made up of a variety of providers, members, and plan administrators. I serve on one of those committees and my experience has been that the MCO's are eager to listen and understand what the frustrations are and are overwhelmed by merely trying to begin managing their services. Although it is frustrating, they feel they are doing the best they can and are also experiencing a level of chaos within their organizations. This is going to take some time.
A continuation of the previous question.

The in-network information has often not crossed over from the executed contracts and into the billing software, so claims payment has been reduced, delayed, or denied.

Clients and their caregivers remain confused and every situation represents the potential for a line of questions with few answers and slow responses.

As you can also see by the last comment, there is a desire and a hope for Managed Care to invest in prevention and care coordination and to ‘hire’ public health agencies to do that work. I don’t see this request disappearing any time soon.
At Iowa’s annual Public Health Conference, our Governor spoke about the success of managed care implementation 2 weeks into the work. This was not popular with the audience and many took his request for comments to discuss the failures and fears in mass.

Iowa had a robust transition of services (nearly all of them) in a short amount of time (8 months). No one except the Governor’s office expected it to go smoothly. The disagreement about its success and the cost savings this model represents is still strong. There is a legislative oversight committee for Managed Care and the legislators have been open to listening to and addressing the needs of their constituents. We are hoping this continues until more solid ground can be identified.
In these answers, the resounding theme is that there are no advantages. We are still grieving the loss of a system we felt worked.

There is some hope and acknowledgement that solution based conversations need to occur. Time will tell if there are changes in health behavior and utilization of health services within the members and across Iowa’s population.
There are strong advocates out there and legislators who are willing to listen. AND... agencies are speaking up and not just about their rate of reimbursement or their bottom lines, but about health and individual circumstances of their clients and the need for prevention and investment. These are some of the greatest outcomes to date and personally, I believe some alignment of providers and public health leaders will occur as a result.

Community representatives from each MCO have been extremely active in public health programs and in communities. We hope this will continue and the connections made will be permanent.
I do have information that the MCO’s are working together on some projects like the Health Risk Assessments and how they might provide the data back to local public health agencies to promote planning and prevention.

I personally appreciated the last comment on your screen: looking beyond enrolled members and toward environmental and social strategies... There is a window here and it is wide open. Who else can we bring to the table to have this discussion?
Social Determinants and Prevention: where is there opportunity?
DPH involvement in contracting with the MCOs?
Working through our issues related to authorizations and payment

While frustration and fear still exist, there is still a great deal of hope and much room for improvement. Representation from our state agency and from advocacy and policy organizations along with the ears and hearts of our legislators can only move this needle in a positive direction. Here is where we can use our voices and voices of our communities to create changes that positively impact health.
While there were no questions from the audience, representatives from many states came after the presentation to acknowledge that their experiences were much like Iowa’s. An attendee from Tennessee advised that Iowa’s story sounded much like the story of TennCare and suggested we publish our story just as they did. A timeline for TennCare can be found here:
http://www.memphis.edu/mlche/pdfs/tenncare/tenncare_bulleted_timeline.pdf