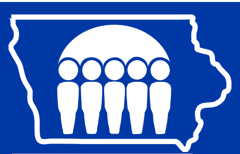
Medical Contracts



Purpose	The department implemented the IA Health Link managed care program for the majority of the Medicaid population on April 1, 2016. Most Medicaid members are now being served by three managed care companies, or managed care organizations (MCOs). The Iowa Medicaid Enterprise (IME) continues to operate a fee for service program for the Medicaid members not enrolled in managed care. Medical contracts include those contracts that enable IME staff as the federally designated single state Medicaid agency to operate the fee-for-service (FFS) program, oversee the MCOs, and operations required for the overall Medicaid program. To carry out these functions, IME has 41 full time state employees, including 14 Health Insurance premium Payment (HIPP) staff. There are 9 performance based contracts with vendors which serve as the primary support to IME staff for both the MCO and FFS programs. With the implementation of managed care, other specialized vendors have been added. In addition to these contracts, IME has a host of contracts with other state agencies and entities to provide services and activities to support Medicaid, ***hawk-i***, and Iowa Health and Wellness Plan members.
Who Is Helped	Vendors enable IME to operate the state Medicaid and ***hawk-I*** programs. Medicaid membership fluctuates, and it generally serves around 650,000 members through the various programs. About 575,000 to 600,000 members are served in managed care and from 40,000 to 70,000 are served in the FFS program. Many served in the FFS program will transition into managed care after their initial enrollment period.
Services	IME has a total of 55 contracts. The following are the primary contracts pertaining to fee for service and MCO and the remaining contracts are with a variety of agencies to provide related services. **External Quality Review Organization (EQRO)** carries out review and quality assurance functions required by CMS. These functions are designed to assure the integrity of the managed care services. **Core Services** processes all fee for service claims, processes managed care organization capitation rates, operates systems including the Medicaid Management Information System (MMIS) and manages the mailroom operations. **Medical Services** provides clinical support such as performs all initial Level of Care (LCO) decisions for waiver and institutional care; approves MCO recommended LOC changes and all FFS LOC reviews, provides utilization management and quality assurance for the fee for service members and carries out quality assurance for both the FFS and the managed care programs. **Member Services** is the State's Medicaid Managed Care enrollment broker. It provides customer services to the fee for service population and provides assistance to members seeking issue resolution with the managed care organizations. **Milliman** establishes the managed care capitation rates and assists in the review of expenditures data. **Pharmacy Medical Services** maintains the Preferred Drug List (PDL) that applies to all Medicaid members. In addition this vendor processes prior authorization (PA) requests and answers the Pharmacy Hotline for FFS members. **Pharmacy Point of Sale (POS)** collects drug rebates from manufacturers. In addition this vendor responds to pharmacy provider questions and processes FFS pharmacy claims. **Program Integrity (PI)** identifies potential fraud, waste and abuse through oversight and cost avoidance strategies. PI coordinates with the department, the MCOs, the Attorney General's Office and the Medicaid Fraud Control Unit (MFCU) in the Department of Inspections and Appeals. In addition PI will assist in validating managed care data.

Provider Cost Audit and Rate Setting performs rate setting, cost settlement and cost audit functions and technical assistance to both providers and managed care organizations. Provider rates serve as the rate floor for managed care organizations unless otherwise negotiated.

Provider Services enrolls all Medicaid providers including FFS and managed care. Provider Services provides direct support to providers in the fee for service programs and coordinates with the managed care organizations to provide training to providers. In addition, Provider Services provide assistance to providers seeking issue resolution with the managed care organizations.

Revenue Collections carries out Third Party Liability (TPL) functions for the fee for service members and estate recovery for all members.

3M implements the Value Index Score (VIS) for quality measurement used by MCOs and providers. The VIS is used to inform value based purchasing of health care services which is a MCO contractual requirement.

University of Iowa reports HEDIS and CAHPS measures which are indications of health care outcomes for both the FFS program and the MCOs.

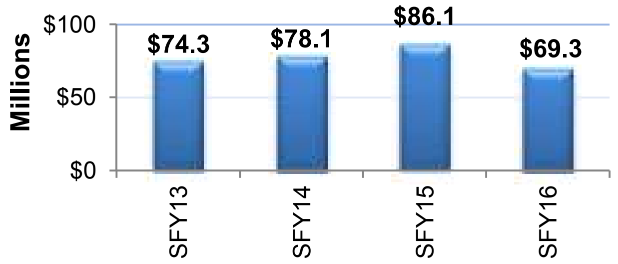
- ✓ *Medicaid processed over 32 million claims in SFY16. The average time from the receipt of an electronic claim form to payment was six days in SFY16.*
- ✓ *Program Integrity saved Medicaid $43.84 million in SFY16 through the identification of overpayments, coding errors, and fraud, waste and abuse. The Recovery Audit contract accounted for approximately $8.0 million of the $43.84 million recovered.*
- ✓ *Historical program integrity and third party liability recoveries were irrelevant in the development of initial managed care capitation rates. MCOs are expected to be at least as efficient at recovery of inappropriate Medicaid payments as Iowa Medicaid was in FFS.*

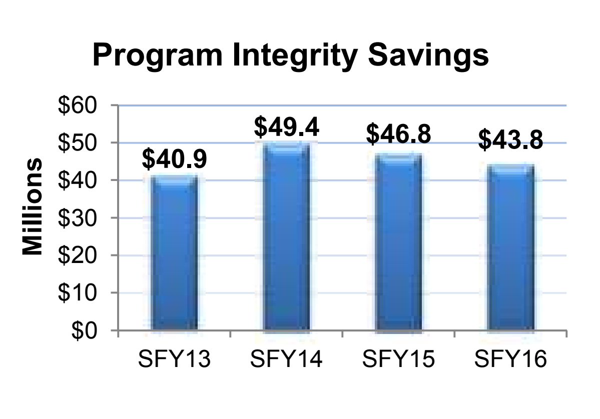
Goals & Strategies

By modernizing the Medicaid program, the IA Health Link initiative aims to:

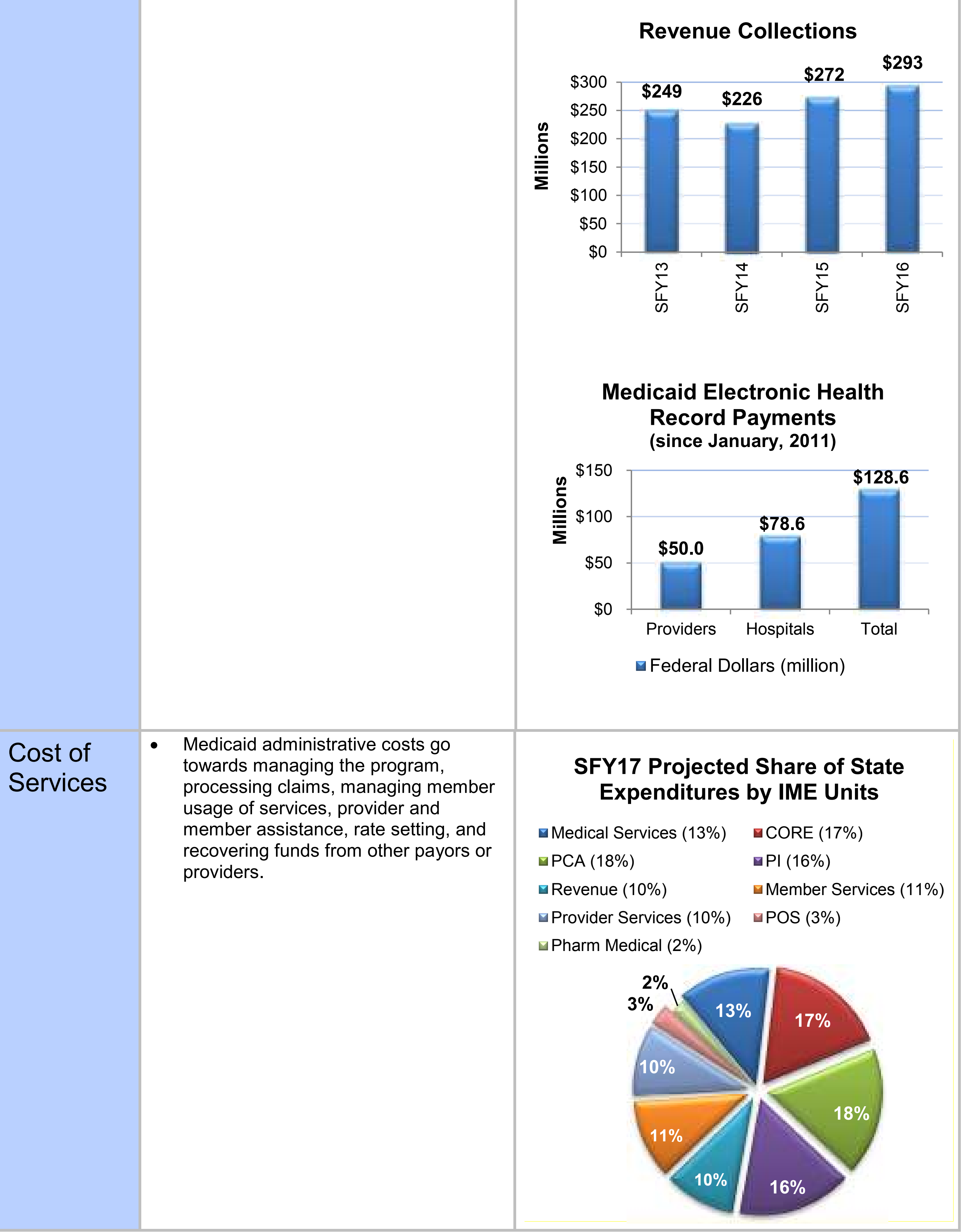
- Improve quality and access
- Promote accountability for outcomes
- Create a more predictable and sustainable Medicaid budget

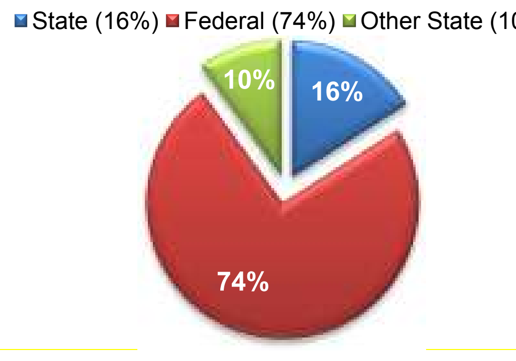
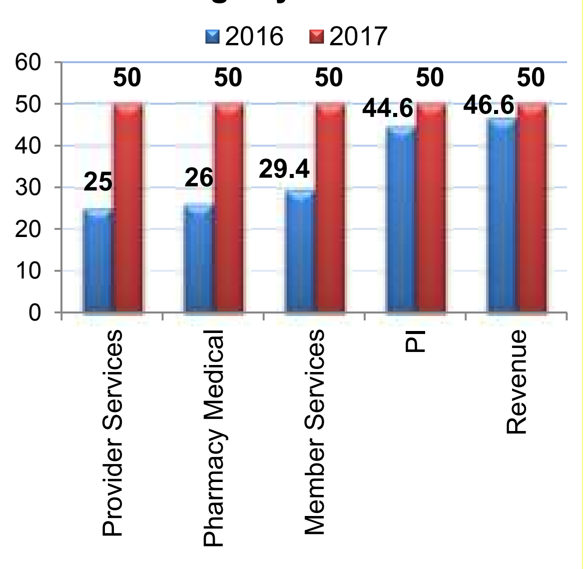
Results:





Cost of Services	• Medicaid administrative costs go towards managing the program, processing claims, managing member usage of services, provider and member assistance, rate setting, and recovering funds from other payors or providers.	



Funding Sources	• IME Medical Contracts are funded with state and matching federal funds. • The state share of funding varies for each contract ranging from 10 percent (e.g. system development), 25 percent (e.g. CORE, Medical Services, and Provider Services) to 50 percent for others (e.g. Revenue Collections, PCA). • The federal matching rate is determined by the makeup of vendor personnel and activities performed.	 
SFY18 & SFY19 Budget Drivers	This request includes $1,268,000 to replace one-time Autism Support carry-forward funds appropriated in SFY17 that will not be available in SFY18 or SFY19.	
Legal Basis	**Federal:** • Title XIX of the Social Security Act. 42 CFR 434.1. Section 1902(a) (4) of the Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan. 434.1(b) sets forth the requirements for contracts with certain organizations for furnishing Medicaid services or processing or paying Medicaid claims or enhancing the agency's capability for effective administration of the program.	