Iowa Department of Human Services

IA Health Link: New Contract Summary

Executive Summary

The Department of Human Services (DHS) has successfully negotiated contracts for the IA Health Link managed care program, which have been signed by Amerigroup of Iowa and UnitedHealthcare Plan of the River Valley for State Fiscal Year 19 (SFY19). Along with updating rates to reflect actual experience, the new contract makes several improvements to the program related to performance requirements, time requirements for processing claims, mental health legislation, and oversight of our managed care partners.

Contract Changes and Improvements

The new contract includes changes designed to improve the program for both members and providers. Revised continuity of care provisions ensure members have consistent access to services and that information is appropriately transferred between providers in order to reduce the risk of hospitalization or institutionalization. Members will also be able to seek a second medical opinion outside the network, at no cost to the member. Credentialing standards are clarified to ensure a more efficient process for providers. The timeliness of credentialing is now measured to include any and all necessary functions performed after complete credentialing packet materials are submitted by the provider, including reviews. The contract also addresses timely claims payment by establishing clear guidelines for claims reprocessing and adjustments.

Long-Term Services and Supports

The contract promotes the State's goal of serving individuals in integrated community settings through increased member participation and more improved standards relating to community-based manager (CBCM) contacts. To support the requirement that members are to participate in the development of their care plans, the performance measures now require that 90% of surveyed members feel they have been a part of their service planning. (See Table A) CBCMs shall, at a minimum, contact home- and community-based services (HCBS) waiver members either in person or by telephone at least monthly. These members shall be visited in their residence or location of service face-to-face as frequently as necessary, but at least every three months. In addition, the new contract prohibits arbitrary reductions in staffing for those who require individualized, enhanced staffing.

Mental Health

The contract prioritizes mental health services and supports comprehensive reform passed in the 2018 legislative session. Language related to members who have been ordered by a court to undergo mental health and substance use disorder (SUD) treatment is updated to ensure appropriate coverage. MCOs are required to reimburse for all mental health and SUD services ordered for members through a court action for three days, regardless of medical necessity. Finally, the contract requires the MCOs to

work collaboratively with the mental health and disability services (MHDS) regions in supporting intensive residential service homes and access centers.

Performance Measures

The State is committed to providing strong oversight of our managed care partners. Contractually-defined performance measures are an important piece of that oversight. This contract updates performance measures tied to the medical capitation payments to reflect the State's priorities and to focus on improved health outcomes.

Summary of Performance Measures	
Claims Reprocessing and Adjustments	The MCOs shall adjudicate ninety-five percent (95%) of all clean provider-initiated adjustment requests within thirty (30) business days of receipt. The MCO shall also reprocess all claims processed in error within thirty (30) business days of identification of the error.
Home- and Community-Based Services Care Plan and Case Notes Audit	The MCOs must demonstrate compliance with eleven explicit requirements related to members' services care plan and case notes to be verified by DHS audit.
Home- and Community-Based Services	Ensures members are a part of their service planning by establishing a ninety percent (90%) standard that members surveyed feel they are part of service planning. The sample size must be approved by DHS.
Well Child Visits	The MCOs shall increase the rate of well child visits by five percent (5%).
Behavioral Health	The MCOs shall increase the rate of follow up after hospitalization for mental illness within seven days by five percent (5%).
Health Outcomes	The MCOs shall increase the rate of HbA1c testing by three percent (3%).
Emergency Department Usage	The MCOs shall reduce the rate of non-emergent use of the emergency department by five percent (5%).

Table A: This is a high-level summary of performance measures and is not all-inclusive. For comprehensive performance measure information, please refer to Amendment 7[1].

Rates

DHS and the MCOs worked diligently and in good faith to establish and agree to capitation rates which are actuarially sound. SFY19 rates were established and reviewed by an independent actuary. These take into account actual experience and contract changes, which results in a $344.2m total increase in capitation rates, with the state share being $102.9m. This represents an 8.4% total increase from SFY18, which represents a 7.5% increase in state share. Amendment 7 and the SFY19 rates have been submitted to the Centers for Medicare and Medicaid Services (CMS) for approval.

[1] http://dhs.iowa.gov/MED-16-009_Bidders-Library