IOWA MEDICAID MANAGED CARE IMPROVEMENT AND OVERSIGHT BILL (SF 2213 & SF 2305)

Intent: Medicaid managed care should be implemented and administered in a manner that safeguards the interests of Medicaid members, encourages the participation of Medicaid providers and protects the interests of Iowa taxpayers.

- Provides for vigorous government oversight of the privatized Medicaid system including significant stakeholder involvement
- Ensures there are investments in system improvements and not just private company profits
- Requires DHS and the managed care companies to comply with provisions to protect consumers, preserve provider networks, address the unique needs of children and assure accountability.

Key Elements of the Bill

- Requires the **Legislative Health Policy Oversight Committee** created as part of the Legislative Council last session to meet at least quarterly to provide continuing oversight for the publicly funded hawk-i and Medicaid programs.
    - Ensure effective and efficient administration of hawk-i and Medicaid
    - Address stakeholder concerns
    - Monitor program costs and expenditures
    - Ensure the needs of eligible members are being met and health outcomes are improving
- Comprehensive review of program integrity activities
- Creation of a Medicaid Reinvestment Fund
- Strengthens Duties and Authority of the Managed Care Ombudsman Program
- Expansion and Enhancement of the Medical Assistance Advisory Council
- Directs Patient-Centered Health Advisory Council to recommend appropriate alignment with holistic, population-health based approaches
- Directs DHS to undertake specific tasks to improve policies in the areas of: consumer protections, children, provider participation enhancement, rates and payments, data collection, and evaluation and oversight.

Review of program integrity duties

- Requires DHS to convene a workgroup including the Commissioner of Insurance, State Auditor, appropriate IME staff, Attorney General, Long-Term Care Ombudsman and DIA to do all of the following:
    - Review all laws, regulations requirements, guidance, etc. related to managed care program integrity
    - Review use of Medicaid fraud fund
    - Review MLR requirements and necessary data collection
    - Review the capacity of state agencies to ensure managed care program integrity

- Review incentives and penalties to determine adequacy
- Make recommendations regarding the annual external audit review of each MCO
- Report findings and recommendations to Health Policy Oversight Committee, GA and Governor before November 15, 2016 and annually thereafter

Medicaid Reinvestment Fund

- A Medicaid Reinvestment Fund is created to capture savings from the shift to managed care such as:
  - Moving patients from institutional care to community-based services
  - 2% capitation payment withheld for pay-for-performance that is never paid to MCOs
  - An additional 2% withheld to ensure MCOs comply with reporting requirements that isn't paid to MCOs
  - A payment of $5 million (from administration) each by the 3 MCOs to fund the Managed Care Ombudsman Program ($15 million)
  - Recovered excess capitation rates
  - Overpayments recovered under MCO contracts
- Moneys in the fund can only be appropriated by the legislature. Such uses include:
  - Provide necessary resources to protect the interests of consumers and adequate provider participation and ensure program integrity
  - Ensure appropriate reimbursement rates
  - Address workforce shortage issues
  - Provide community based services and reduce HCBS waiting lists
  - Ensure fully-functioning Ombudsman program
  - Ensure DHS has the capacity to oversee the MCOs
  - Innovations and longer-term investments
- DHS shall establish a mechanism to measure and certify the amount of savings resulting from managed care

Long-Term Services and Supports Ombudsman Enhancements

- Evaluate managed care decisions to deny or limit a member's services; reduce or stop a certain service; or changes in level of care
- Receive all notices of disenrollment
- Access results of level of care assessments
- Deem the managed care ombudsman program as a health oversight agency per federal regulations
- DHS and MCOs shall inform Medicaid members of the ombudsman assistance that is available

Enhancements to Medical Assistance-Medicaid-Advisory Council (MAAC)

- MAAC shall participate in Medicaid policy development and program administration and have input into annual budget preparation
- MAAC meets at least quarterly
- Equal number of public members
- MAAC and MAAC Executive Committee Co-Chairs are 1 public member and 1 professional member
- Executive Branch members are non-voting
- The Long Term Care Ombudsman is added to the membership of MAAC and the MAAC Executive Committee
- Several new subcommittees are created:
    - Stakeholder Safeguards
    - Long-Term Services and Supports
    - Transparency, Data and Evaluation
    - Program Integrity
    - Workforce
- The MAAC, Executive Committee and Subcommittees shall report annually to the Governor and General Assembly and Health Policy Oversight Committee summarizing their deliberations and findings and any recommendations for changes in law or policy
- MAAC and committees are authorized to enlist the assistance of experts
- The Patient-Centered Health Advisory Council shall work with the Workforce subcommittee of MAAC
- Directs DHS to apply for federal financial participation funds for MAAC (50/50 match

Medicaid Program Policy Improvement Directives to DHS

- DHS shall direct the MCOs and not defer to them to ensure
    - Consumer Protections
        - Fair and consistent appeal process
        - Continue Medicaid member's benefits during an appeal
        - MCOs provide at a minimum all medically necessary services in the same manner with the same prior authorization criteria as current system and in accordance with state law
        - Enhanced monitoring and data reporting of any reduction in services or increases in waiting lists, etc.
        - Require MCOs to adhere to reasonableness standards and service authorization standards
        - Ensure case management is appropriate and conflict-free and allow Medicaid members to choose to keep their existing case manager beyond the six-month transition
        - Maintain existing provider-member relationships for at least one year--continuity of care

        - Provide access to dental coverage
        - Require MCOs to share encounter data on all services including value-added services
        - Prohibit arbitrary denials based solely on financial reasons
        - Require MCOs to keep records of complaints, grievances, appeals, etc. and report and make those records public
        - Require MCOs to conduct customer satisfaction surveys
        - Address needs of children and maintain child health panels
        - Adds OT as required service for children in hawk-i
        - Provide special incentives for innovative and evidence-based preventive strategies for children
        - Include coverage for children that reflects what is in state law, and is not more restrictive
        - Monitor the quality of children's services, including the provision of EPSDT benefits
        - Allow requests for single case agreements with a recipients out of network provide, i.e., Mayo
        - Make sure costs are not shifted to other non-Medicaid providers
    - Provider Participation Enhancement
        - Rates must be based on state law and rule
        - All MCOs use the same preferred drug list, recommended drug list, prior authorization criteria as fee for service
        - Savings should not be achieved through inadequate provider reimbursement rates
        - Rates must remain the same during the entire contract period
        - Rate protections for hospitals, critical access hospitals, CMHC's and FQHC's, and substance abuse providers
        - Allow providers to submit claims up to 365 days following patient discharge
        - MCOs must include as primary care provider any provider designated by state law as a primary care provider including GP; pediatrician, internist, OBGYN, ARNP, PA or chiropractor
    - Capitation Rates and Medical Loss Ratio
        - Prohibit MCOs from requesting more than 3 percent increase in capitation payment rates in one year or more than 5 percent over 2 years.
        - In addition to withholding 2 percent of an MCO's annual capitation payment as a pay-for-performance enforcement mechanism, the DHS shall also withhold an additional 2 percent of a MCO's payment until DHS is able to ensure that the MCO has complied with all requirements relating to data, information, evaluation and oversight
        - The bill specifies an MLR of 88 percent. This means 88 percent of the payments DHS makes to MCOs (capitated payments) must be spent on actual medical care. The bill specifies 16 expenses that cannot be counted as medical services.

- Data and Information, Evaluation and Oversight
    - DHS must develop and administer a clear, detailed policy regarding the collection, storage, integration, analysis, maintenance, retention, reporting, and sharing of MCO data.
    - MCOs shall allow DHS to thoroughly and accurately monitor data
    - DHS shall conduct regular audits of the MCOs
    - After the first year of managed care, DHS shall hire an independent performance auditor. Results will be submitted to the Governor and General Assembly and the Health Policy Oversight Committee
    - MCOs shall report use of subcontractors and subcontractors shall comply with the same requirements
    - Publish benchmark measure so results of managed care can be compared to fee for service
    - Require consistency and uniformity of processes, procedures and forms across MCOs
    - The hawk-I Board shall provide recommendations to DHS to ensure that MCOs specifically and appropriately address unique pediatric needs