Medicaid Managed Care in Iowa

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This PAE reflects the views of the author(s) and should not be viewed as representing the views of the PAE's external clients, nor those of Harvard University or any of its faculty.
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Executive Summary

On April 1, 2016, the state of Iowa transitioned eighty percent of its Medicaid population from traditional fee-for-service to comprehensive Medicaid managed care. In the wake of this transition, providers across the state confronted dramatically increasing costs due to new prior authorizations and denials of claims. Lengthy authorizations and appeals processes led to unprecedented delays in payment (revenue deceleration) and disputes with the Managed Care Organizations. The MCOs, in turn, defended their authorization processes and claimed that delayed provider payments were a product of the state’s short implementation timeline, the ‘uniqueness’ of Iowa policies, and providers’ lack of readiness to comply with MCOs’ requirements. As political pressure mounted, MCOs also accused the state of misleading them during the procurement process, saying that the state’s capitation rates did not adequately account for their members’ underlying medical costs.

In the time since the transition, UIHC has devoted significant resources to managing authorizations and appeals with MCOs, but the volume of authorizations and unpaid claims has not substantially improved. **This project originated from the question of how UIHC could resolve unpaid claims and improve its collection rate from Medicaid MCOs. As this project progressed, however, it became increasingly important to weigh short-term solutions against the long-term goals of the organization.**

The Problem

To understand the scope and magnitude of the costs due to the transition to managed care, this report uses time-driven-activity-based-costing to quantify the direct and indirect costs of interacting with MCOs.

**Prior Authorizations:** The added cost of completing prior authorizations under managed care is estimated to be at least $1,042,635 and as much as $1.4 million per year.

The exact cost of prior authorizations is difficult to determine because prior authorizations processes are scattered throughout financial and clinical departments. The organic expansion of workflows across the hospital makes it difficult to standardize procedures and negotiate operational improvements with the MCOs.

**Prompt Payment:** The added cost of billing, appealing, and collecting claims under managed care is estimated to be at least $1,106,982 per year and as much as $1.6 million per year.

The majority of this cost appears to be associated with resolving claims that were denied in the months immediately after the managed care transition. Since 2017, the first-pass denial rate has now decreased to the same or lower level than before managed care.

**Together, the added administrative burden after transitioning to managed care is estimated to be at least $2,149,618 and as much as $3 million per year.**
**Supplemental Payments:** In the long-term, UIHC risks facing a much larger fiscal cliff due to changes in federal supplemental payment regulations that apply under managed care.

Under managed care, physician UPL payments are routed to UIHC through the MCOs. The Medicaid Final Rule of 2016 requires that these “pass-through” payments be phased out of managed care contracts by 2022. In order to maintain UIHC’s financial integrity, these payments must either be restructured as value-based payments or be replaced with other forms of funding.

**Recommendations**

Considering the short-term costs and the long-term risks confronting UIHC, the health system should chart a course that addresses short-term costs but that also builds relationships that can help it manage its long-term risk. Ultimately, the most important long-term goals of the organization should be to ensure the integrity of the Medicaid system and restructure its supplemental payments. Building the capacity of the state Medicaid agency and aligning incentives downward, through MCOs, is predicted to simultaneously improve the chances of restructuring supplemental payments and also relieve the incentives that drive unnecessary prior authorizations and payment delays.

**Short-term Recommendations**

- **Address prior authorization rules directly with the MCOs.**
- **Work with the state to advocate for timely payment rules.**
- **Build relationships by advocating for efficiency improvements that are of universal interest.**
- **Streamline front-end prior authorization and billing processes (as recommended by external consultants).**

**Long-term Recommendations**

- **Help IME build the capacities it needs in order to actively manage contracts and fulfill its new role under managed care.**
- **Build a coalition with managed care organizations to advocate for sound actuarial analysis and capitation rates.**
- **Work with IME to restructure supplemental UPL payments.**
Background: Medicaid Managed Care in Iowa

25% of Iowa’s population—767,000 people—rely on Medicaid for health care coverage. On April 1, 2016, the state transitioned 80% of that Medicaid population from traditional fee-for-service (FFS) to Medicaid Managed Care (MMC). Under fee-for-service, the state Medicaid agency, Iowa Medicaid Enterprise, contracted directly with providers to pay for health services at per-service prices. Under Medicaid Managed Care, IME now contracts with private health insurers that are paid a per-person-per-month capitation rate that is adjusted based on the person’s health condition and risks. The private managed care organizations (MCOs), in turn, contract with a provider network and pay those providers per-service rates for providing services to the MCO’s members (see Figure 1). This “privatization of Medicaid management,” was supposed to leverage competition and private insurers’ experience with care coordination to generate efficiencies in the Medicaid system. At the time, Iowa Governor Terry Branstad said the switch would save Iowa $110 million annually in government expenditures. The transition was carried out by executive decision and all Medicaid eligibility groups and special populations were mandatorily enrolled. By July 1, 2016, more than 90% of Iowa’s Medicaid population was covered by three comprehensive Managed Care Organizations (MCOs): AmeriHealth Caritas, Amerigroup, and UnitedHealthcare Community Plan.

Iowa Medicaid at a glance:

- **Total Medicaid Spending:** $4.8 billion
- **State Spending:** $1.8 billion
- **Federal Spending:** $3 billion
- **Federal Match (FMAP):** 58.5%
- **Total Medicaid population:** 630,000 (in 2016)
  - Medicaid: 429,301
  - Hawk-I (CHIP): 44,966
  - Wellness Plan (Expansion): 143,700
- **Percent Comprehensive Managed Care:** 92.6%
- **Carve-in:** Behavioral health, Long-Term Services and Supports (LTSS), Pharmaceuticals
- **Carve-out:** Non-Emergent Medical Transportation (NEMT)
- **MLR:** 88% with remittance
- **Contracts:** Pay for performance bonus and capitation with-hold
- **Value-Based Payment:** None

A more detailed description of Iowa’s current Medicaid Policy Framework is available in Appendix B.

Sources: Iowa DHS, Kaiser Family Foundation, MACPAC, and The Gazette

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1 Comprehensive managed care enrollment in 2015: 12.1% (60,011); in 2017: 92.6% (458,533).
2 The administration, later, was unable to provide data or reports for how this number was generated. https://www.desmoinesregister.com/story/news/investigations/2015/10/14/iowa-cant-show-math-medicaid-savings-estimate/73922744/
In the spring of 2016, the Branstad Administration publicized the transition not only as a “privatization” but as a “modernization”. Most other states operated some kind of managed care program, and in 28 states more than 75% of Medicaid members were enrolled in comprehensive risk-based managed care (similar to Iowa’s new managed care system). Managed care was particular popular in states that participated in the Medicaid expansion, as Iowa did. By making its managed care transition, Iowa joined 10 other states where managed care penetration was over 90%.

Although Iowa had never delegated so much of its population to MCOs, it was not the first time Iowa had contracted parts of its Medicaid program under managed care. The state had 23 years of experience operating a Primary Care Case Management (PCCM) program called MediPASS, an 8-year history of contracting behavioral health services under a managed care agreement with Magellan, and even a two-year history of experimenting with comprehensive managed care for a small portion of its Medicaid population with Meridian Health. Despite these previous contracts, however, “Medicaid managed care” was a new idea for most Iowans—one that conjured memories of HMOs and the “Managed Care Revolution” of the 1990s.

It was also a rapid change. The governor announced the request for proposals in February 2015 with the intent to transition to managed care in January 2016, less than twelve months later. The launch of managed care was ultimately delayed until April because it was twice postponed by CMS for inadequate provider networks and communication.

Figure 1. Traditional FFS Medicaid and Managed Care Comparison. Under traditional FFS, the state contracts with providers (purple, red, green) on a fee-for-service basis to deliver services to patients (blue). Under managed care, the state contracts with managed care organizations (MCOs) on a per-member-per-month basis at an agreed upon capitation rate, adjusted for members’ predicted health risks. Each MCO, in turn, contracts with its own network of providers to deliver services to patients.
Iowa has a long history of health and welfare programs for low-income families. The diagram above depicts the evolution of indigent care programs, simplified based on the federal poverty levels (FPL) that the programs applied to. The Iowa Indigent Care, or “State Papers”, Program was created in 1915, 50 years before Medicare and Medicaid—as a healthcare safety net for low-income Iowans. In 1965, Iowa accepted federal funds through Title XIX of the Social Security Act to start the state’s Medicaid program. Forty years later, Iowa began the IowaCare program as an 1115 Demonstration Waiver to provide basic healthcare coverage for adults who did not otherwise qualify for Medicaid. On January 1, 2014, after extended negotiations with the federal government allowed it to obtain two 1115 waivers, Iowa implemented the Iowa Health and Wellness Plan (IHAWP), Iowa’s version of the ACA’s Medicaid Expansion. IHAWP replaced the previous IowaCare program with two new programs: Iowa Marketplace Choice and the Iowa Wellness Plan. Marketplace choice required Medicaid beneficiaries to use their Medicaid dollars to purchase coverage through the exchange from certain Qualified Health Plans (QHPs). In 2015, however, all QHPs stopped accepting Medicaid members and the marketplace collapsed. In April 2016, Iowa transitioned almost all of its Medicaid members onto Iowa Health Link, also known as Medicaid managed care.

For a more detailed history of Iowa’s Medicaid program, see Appendix A.
Shortly after the transition to managed care, medical providers across Iowa began to protest delayed payments, lengthy prior authorizations, and adversarial negotiations with all three MCOs. The MCOs, in turn, claimed that delayed provider payments were due to the short implementation timeline, the ‘uniqueness’ of Iowa policies versus other states and provider’s lack of readiness and compliance with their requirements. As political pressure grew, the MCOs stated that capitation rates were insufficient due to inadequate accounting for member’s underlying medical costs.

Citing such concerns, AmeriHealth, one of the three MCOs, terminated its contract with the state as of December 1, 2017. AmeriHealth’s executives publically asserted that Iowa had concealed parts of its Medicaid data, resulting in unsound capitation rates. In a letter to the Department of Human Services, AmeriHealth’s president wrote that the state’s rates “do not support a sustainable Medicaid managed-care program”.

AmeriHealth’s grievances centered on the Intellectual Disability Waiver population—a group of about twelve thousand Medicaid recipients who are allotted a higher per-month capitation rate because of their need for expensive services like adult home care. During the initial managed care enrollment, AmeriHealth promised new enrollees the ability to maintain their existing in-home provider—a benefit that appealed to members who had built an intimate relationship with their in-home aide(s). This benefit likely contributed to AmeriHealth aggregating nearly 80% of the Intellectual Disability Waiver population. AmeriHealth cited this population as one of its primary rate concerns and hired an external consultancy, Wakley, to compare the 2015 data the state used to set capitation rates with the company’s actual costs in 2016. Wakley found that AmeriHealth’s costs exceeded rate-setting assumptions for these high-cost populations by as much as 31 percent, or $1065 per month.

Along with the other managed care organizations, AmeriHealth had begun posting losses of tens of millions of dollars. After Wakley’s analysis, AmeriHealth subsequently requested a 15 percent capitation rate increase as well as $75 million in reimbursements from the state in order to recover a portion of its losses. The state, however, defended its rates and the reputation of Milliman, the actuarial company that it contracted to set them. With no deal, AmeriHealth announced it would terminate its contract on October 31, 2017.

In the subsequent weeks, UnitedHealthcare and Amerigroup were granted a 3.3% capitation rate increase for FY2017, retroactive to July 1, 2016. The cost of that rate increase amounted to approximately $140 million to both federal and state government.
AmeriHealth’s exit prompted a major shift in member enrollment as it necessitated the reassignment of its more than 213,000 Medicaid members. Initially, Iowa gave members the choice of enrolling into one of the two remaining managed care plans (Amerigroup or UnitedHealthcare). Shortly after Iowa’s announcement, however, Amerigroup announced that it did “not have the capacity to take additional members, including those who have actively chosen Amerigroup Iowa as their (managed-care organization) after AmeriHealth Caritas’ withdrawal.”

This left UnitedHealthcare as the only MCO accepting new members, which put Iowa’s managed care waiver in jeopardy. Under the federal waiver, Iowa was allowed to operate a managed care program only so long as members had a “choice” between managed care organizations. With only UnitedHealthcare accepting new members, Iowa did not meet this requirement. Iowa filed an emergent request with CMS in early November to waive the requirement for “choice”, and, after some confusion about whether such a waiver was possible, CMS announced that, given the emergent context, federal approval was not necessary.

With the requirement for choice temporarily waived, nearly all of AmeriHealth’s 213,000 members were switched to UnitedHealthcare with the expectation that Amerigroup would build enough capacity in order to start accepting new members in spring 2018. The state has stated that it intends to contract with a third MCO beginning July 1, 2018, but many Medicaid members have lost confidence in the stability of their care.

A new Department of Human Services Director, Jerry Foxhoven, is charged with renegotiating the state’s contracts with the MCOs, which will be retroactive to July 1. Meanwhile, medical providers such as University of Iowa Health Care (UIHC) and the University of Iowa Health Alliance (UIHA) are deciding how to renegotiate their own contracts with the MCOs.
The Problem

Ever since the transition to managed care, UIHC, like other providers across the state, has encountered problems with prior authorizations and prompt payment with all three MCOs.

More specifically, UIHC experienced an increase in the frequency of prior authorizations required by MCOs, an increase in the rate of denials for those authorizations, and an increase in the rate of denials of the claims generated by providing health services. Lack of prior authorization and denials of claims both contributed to unprecedented delays in payment (also known as “revenue deceleration”) as UIHC began the lengthy appeal process of attempting to overturn those denials. UIHC has devoted significant resources to managing authorizations and appeals with each MCO, but the total quantity of unpaid claims has not substantially improved.

Because of its role as a state entity under the board of regents, UIHC is in a unique position relative to its peers in terms of its ability to renegotiate contracts or bring grievances before the state administration. Whereas other health systems may choose to terminate their contracts with an MCO or enter into aggressive negotiations, UIHC is bound by its mission to serve as a tertiary care center and safety net for all of Iowa’s Medicaid members. As the costs of managed care have risen, so has the tension between UIHC’s financial security and its mission.

Central Questions

This project originated from the central question:

- How can UIHC decrease aged claims in accounts receivable or improve its collection rate from Medicaid MCOs?

As this project progressed, however, it became increasingly important to weigh short-term solutions to that question against the long-term goals of the organization. To do this, it became important to ask:

- What are the scope and magnitude of the costs associated with the managed care transition?

- How have other states addressed prior authorizations and guaranteed timely payment?

- How can UIHC structure its political and business negotiations in order to balance its short-term costs and long-term risks?
The Costs of Managed Care

Extensive health economics research suggests that a third or more of U.S. health care costs may be wasteful. Managed care claims to reduce those unnecessary health care costs while maintaining or improving the quality of care. To do this, managed care leverages a variety of tools, including economic incentives such as patient and provider cost sharing that encourages the use of cheaper health services; selective contracting between payers and low-cost or high-quality providers; care coordination between providers; intensive case management for high-cost patients; and utilization management in the form of prior authorization and medical necessity determination.

Since its origin in the 1980s, managed care has become the dominant system for paying for and delivering healthcare in the United States—ubiquitous among both commercial payers and Medicare. Medicaid was not insulated from this movement. States began to employ Medicaid managed care systems in the early 1990s, often transitioning different categories of members onto managed care in a staggered fashion (children, parents, disabled). More recently, states have also begun to transition their long term care members onto managed long term care plans, or combine them into integrated Medicaid/Medicare managed care plans.

State Medicaid agencies might have developed the capacity to apply managed care techniques themselves, but without the experience in using the tools of managed care (and for more reasons described later) states typically contracted with private insurers to administer their Medicaid dollars and manage the Medicaid delivery system. Another key reason for using MCOs was the flexibility afforded by the 1915b waivers that approved such systems. Under 1915b, MCOs had the flexibility to create incentive programs and cover services that Medicaid fee-for-service was unable to offer under federal rules. Finally, employing managed care and budgeting for a fixed capitated rate per Medicaid member allowed the state to shift the risk of volatile Medicaid spending onto the managed care companies. The results of this decision in terms of cost and quality of care are mixed and highly disputed.

Because of its ostensive efficiencies, managed care is often billed as a cost containment or—as is the case in Iowa—a cost-savings measure for the state and, therefore, taxpayers. From a public

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Costs of Managed Care

**Patient:**
- Hassle of Patient Enrollment
- Hassle of obtaining and appealing Prior Authorizations
- Health impact of Delayed or Denied Care

**Payer (Managed Care Organization):**
- Hassle of Patient and Provider Enrollment
- Hassle of Prior Authorizations
- Hassle of Billing and Payment Collection

**Provider:**
- Hassle of Provider Enrollment
- Hassle of Prior Authorization
- Hassle of Billing and Payment Collection
- Lost Revenue due to decreased service utilization and unpaid claims
- Lost time value of money and opportunity costs due to Revenue Deceleration and Delayed Payment.

**State:**
- Administrative cost of contracting with MCOs, auditors, and actuarial consultancies
- Hassle of applying for and renewing CMS authorization for managed care
good standpoint, however, the magnitude of these savings should be weighed against the hassle and inefficiencies generated in other parts of the health care system.

For patients, managed care imposes the added hassle of choosing, enrolling, and maintaining membership with a managed care organization. Managed care also subjects patients to the same prior authorization and appeals processes that it applies to providers, imposing the hassle of navigating the authorization process on their own or with their provider in order to obtain necessary services. Patients and advocacy groups across the nation contend that managed care discourages the provision of necessary services and encourages the use of low-quality services. In Iowa, the advent of Medicaid managed care has been accompanied by alarming reports of denied or delayed care for Medicaid members who are elderly and disabled. In January the state agreed to review approximately 200 appeals cases after investigative journalists uncovered a “systemic” pattern of denials for long-term-care.

For the managed care organization, managed care presents the opportunity to earn a margin on the difference between the capitated payment from the state and the cost of service delivery plus the costs of administrating the provider contracts, authorizations, and appeals. These administrative costs are a present across MCOs and should be compared to the administrative costs of these processes under the state plan.

The costs to patients, MCOs, and the state are important but beyond the scope of this report. Nevertheless, it is important to consider them when evaluating the political feasibility of various actions. The remainder of this section focuses on the costs of managed care to the provider.

The costs of managed care for the provider include both the administrative costs of interacting with MCOs (tasks like completing prior authorizations, billing, and collecting payment) and the changes in revenue due to changes in covered benefits, market power of each actor, and political pressure, all of which augment the price negotiations between provider and payer. As a state entity under the authority of the state Board of Regents, UIHC occupies and especially unique political position relative to its peers (described in Appendix F).

- **Lost revenue due to lower reimbursement and unpaid claims.** For the last four years, UIHC has faced steadily decreasing collection rates with its Medicaid payers. Collection rates decreased by approximately 1% per year through the managed care transition; UIHC suspects that this trend would have been steeper if the health system had not invested so heavily in completing prior authorizations and appealing denied claims. One might expect an appropriate decrease in collection rate under managed care if there was significant fraud or waste in the Medicaid system and MCOs could accurately identify that waste. UIHC’s success rate in overturning denials, however, suggests that many denials are inaccurate and so are generating their own form of inefficiency. Indeed, working to appeal claims and proving medical necessity has generated significant administrative cost to the provider (evaluated in the following section).

- **Lost revenue due to revenue deceleration.** Payment collection in healthcare generally lags weeks to months behind the time of claim submission. This time is lengthened if the payer requires additional documentation or if denials are appealed and reprocessed. As an unpaid claim ages, it moves into sequentially older “buckets” – greater than 90 days,
greater than 180 days, and greater than 270 days. Once the claim ages into the 270-day bucket, the claim is typically written off as a loss (which decreases the provider’s collection rate). Even if that claim is eventually paid out of the 270-day bucket, however, that payment still comes with a cost to the health system money because the net present value of that charge has decreased over time due to inflation and the lost opportunity cost of those dollars.iii The prior authorization and claims appeal processes with Medicaid payers generated high rates of old, or “aged”, claims under both traditional Medicaid and Medicaid Managed Care. After the managed care transition, the quantity unpaid claims in accounts receivable stayed approximately constant, but the payer for those claims switched from Iowa Medicaid Enterprise to the MCOs (see Figure 2). Again, UIHC expects that the quantity of aged claims would have increased if it had not invested in appealing denied claims. Controlling the quantity of unpaid claims in accounts receivable has generated significant administrative cost (discussed in the next section).

![Figure 2. Total Unpaid Medicaid Accounts Receivable Charges Older than 270 Days. Between January 2017 and January 2018, the amount of unpaid charges with IME as the payer declined (orange line) and the amount with MCOs as the payer increased (blue line). The total amount of unpaid charges, however, remained relatively constant (gray lines, dotted is monthly, solid is trend).](image)

iii MCOs are contractually required to pay interest on claims, but that interest is calculated from the time the claim is “clean”, meaning the time at which the claim is deemed to have all necessary documentation and have proven medical necessity. The majority of time that a claim is in dispute, the MCO does not consider the claim to be “clean”.
The Administrative Cost of Interacting with MCOs

There are three types of administrative costs of interacting with payers in a health system. Authors David Cutler and Dan Ly categorize these as “credentialing,” “verifying eligibility for services,” and “billing and payment collection.” For the purpose of this project, these categories are nearly analogous to “provider enrollment,” “prior authorization,” and “prompt payment.” All three of these costs existed under the previous FFS system. Managed care, however, increased all three.

(1) **Credentialing** (provider enrollment) — It is common to confuse credentialing as it relates to Medicaid recipients—who must verify their eligibility, enroll, and renew their membership in order to receive Medicaid benefits—with credentialing as it relates to providers. In a similar process as patients, providers must also verify their credentials, enroll, and be loaded into the provider network with the payers (both Iowa Medicaid Enterprise and the MCOs) in order to be paid for services rendered. Sometimes, as is the case with UIHC, MCOs may agree to enter into a Designated Credentialing Agreement with a provider group, thereby delegating responsibility for verifying physician’s credentials to the hospital system. Delayed enrollment, and delayed loading of physicians’ data into the payers’ system, however, is a common cause of claim denials.

(2) **Verifying eligibility for services** (prior authorization) — A Medicaid member’s eligibility for services depends on their assigned benefits and whether those benefits are determined to be medically necessary. Many benefits require no authorization for coverage. In Medicaid managed care, and increasingly among other payers, specialty or high-cost services require prior authorization from the payer in order to be covered. Querying the payer to obtain prior authorization involves sending a request, preparing medical documentation, and appealing a request if authorization is denied.

(3) **Billing and payment collection** (prompt payment). Upon completion of a service, the provider bundles charges associated with that encounter and sends them to the payer in an invoice. To this invoice, the provider appends the requisite medical documentation for the service, member information, and, if necessary, authorization numbers. An invoice may be denied, in whole or in part, for numerous reasons, including insufficient documentation, member’s eligibility for the service, disputes over coordination of the payment with any other coverage the member may have, timeliness of the invoice’s filing, coding errors on the part of the provider or payer, and failure to obtain the appropriate authorizations before the service. Appealing a claim denial begins an infinite cycle of resubmitting and reprocessing the claim. Rarely, such a process may be interrupted by appealing to a higher authority or by legal action. When a claim is approved, the payer pays the charges at rates that are pre-negotiated between the payer and the provider but that are usually much less than the amount billed on the invoice. The fraction of these payments to the total amount billed by the provider is known as the collection rate.

Because provider enrollment costs are small relative to prior authorization and payment collection, and because the bulk of costs associated with provider enrollment arises as denials
during billing and payment process, this project focuses on the administrative costs only of
prior authorizations and billing and payment collection.

Previous to managed care, Medicaid, similar to Medicare, imposed a smaller administrative
burden on providers; there were utilization review or prior authorization processes in place, but
the hassle associated with these activities was more comparable to commercial payers. iv On the
other hand, Medicaid paid and continues to pay less than other commercial payers. Under the
traditional Medicaid system, there was a tacit understanding that providers accept lower
reimbursement, in part, because of the lower administrative cost of interacting with the state
Medicaid plan. Medicaid, with its lower reimbursement rate, had an incentive to pay providers
timely, and the payment process was less confusing with only one payer. When the Medicaid
system moved to managed care, providers paid more in administrative cost with no change in
the Medicaid rates.18 Unsurprisingly, increased administrative cost of interacting with MCOs is
cited as the main reason why many providers in Iowa terminate their contracts with MCOs or
leave the Medicaid network altogether.19

Reasons for High Administrative Costs

By introducing a new party (MCOs) into the Medicaid system, managed care undoubtedly
complicates the relationship between patients, providers, and payers. Even if there were no
change in the rate of prior authorizations or denials, providers now interact with three payers
where before there was one; each payer bringing its own contract negotiations, authorization
processes, and billing system. This duplication of administrative processes generates an
administrative burden on its own. As we attempt to measure this and other administrative costs
under managed care, it is important to consider reasons why a state might switch to managed
care and why administrative costs in healthcare, more generally, remain so high.
Administrative costs in most other industries, after all, have decreased over time.18

Proponents of managed care are quick to cite efficiency gains due to competition and enhanced
care coordination.15 Critics of managed care, however, tend to identify other, more subtle
reasons that managed care is attractive to state governments. First, managed care shifts the risk
in Medicaid expenditures from the state to the managed care organizations. With rising
healthcare costs, new high-cost medications, and broad swings in Medicaid enrollment due to
economic conditions, Medicaid has become a volatile line-item in state budgets. Issuing a
capitated payment to MCOs adds predictability, making it easier to balance the books and

iv IME contracted with Telligen to perform utilization management, utilization review, and prior authorization for
services (except for the behavioral health services that were already delegated to managed care under Magellan).
budget for other expenses. Second, managed care distances the state from painful oversight and financial decisions. “Managed care,” after all, is based on the idea that a portion of health care utilization is wasteful and so care needs to be “managed” by way of verifying the medical necessity of services. Legislators on both sides of the isle want to curb rising healthcare costs, but with one in five Americans employed by the health care industry, applying direct oversight and fiscal pressure through the state Medicaid system is quick to incite political retaliation. Introducing a middle-man in the form of a managed care organization allows another party to absorb some of the political blow-back.

Cutler & Ly sort the reasons for health care’s high administrative costs into three categories:

(1) **Lack of coordination** — As mentioned above, the duplication of administrative processes generates inefficiencies due to discrepancies between payers and providers. This problem is not unique to health care but is nonetheless a continued cost when no standard is imposed by a powerful actor or cooperatively created.

(2) **Complexity discourages healthcare utilization** — Complexity may be useful to MCOs and the state if it lowers the volume and ultimately the cost of health care. Denying pre-authorizations reduces cost if the service is never provided. Similarly, denying claims saves the payer money if a service is never reimbursed or if the present value of payments for services is reduced (as the value decreases because of inflation).

(3) **High administrative costs may be necessary to prevent fraud** — In a FFS system, there is an incentive to provide more services than necessary so long as price outweighs marginal cost. This incentive should be weaker in Medicaid because price is lower than Medicare or other commercial payers. However, the marginal cost of health services is highly disputed and not well-understood.

In the following section we attempt to quantify the administrative costs of interacting with MCOs. Where possible, we compare current administrative costs to the administrative costs under the previous traditional Medicaid system. We also attempt to identify the root cause (from the reasons above) of these costs.
Prior Authorizations

Prior Authorizations include authorizations required for inpatient services (pre-certifications), outpatient or ambulatory services (pre-authorizations), and HMO referrals. The capacity for completing these authorizations has developed organically across the hospital, resulting in the administrative burden being spread across clinical departments, administrative departments, and financial services.

Utilization Management

The majority of inpatient authorizations have been centralized under the office of Utilization Management (UM), where a team of eight nurses completes authorization processes like that described in the following diagram (Figure 3).

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**Figure 3. Pre-certification Workflow for Inpatient Admission.** Obtaining approval for inpatient admission requires that the provider, on bottom, notify the Managed Care Organization (MCO), complete a “pre-cert”, send clinical documentation, and sometimes complete a peer-to-peer or submit a written appeal. The MCO, on top, must track notifications, review documentation, complete peer-to-peers, and review written appeals, issuing an approval or denial each time based on the available information. The sequence of interactions is described in the flow-chart above. Percent of total authorizations that progress to each step in the flowchart are estimated in bold. Examples of contractual time limits for each party to complete the necessary activity are included together with that activity.
As depicted, when a patient presents for an unscheduled admission, UIHC sends a notification, together with available clinical documentation, to the MCO, which may approve or deny the admission. If the MCO cannot immediately approve this level of care based on the information provided, it will request additional clinical documentation. The MCO then reviews that documentation and approves or denies the admission. If the MCO denies, UIHC may appeal the decision by setting up a “peer-to-peer” between a UIHC physician and the medical director of the MCO. If the appeal is still denied after peer-to-peer, UIHC may submit a written appeal to the MCO, and, if denied, may continue to resubmit that appeal. By this point, the patient is likely discharged from their inpatient stay and the relevant charges have been bundled and sent to the MCO. At this point, the interaction between UM and the payer is joined by Patient Financial Services (PFS), which is the UIHC department responsible for billing and payment collection. If a claim is denied for lack of prior authorization, PFS may work with UM to appeal the claim for medical necessity. If UIHC believes the claim is still being denied inappropriately, PFS may also elevate the claim to an “issues log” that is shared with the MCO. PFS and the MCO work together to maintain and revisit the issues log in effort to settle those claims.

Before the transition to Medicaid managed care, Utilization Management only needed to complete pre-certifications for behavioral health admissions. After the transition, UM was required to complete pre-certification for all inpatient admissions with MCO payers. UM was also required to complete pre-certification renewals over the course of an inpatient stay. These perfunctory notification, precertification, and renewal processes, alone, are estimated to have

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**Time-Driven-Activity-Based-Costing**

TDABC is a budgeting technique used to determine the per-unit cost of activities.

Per-unit costs in health care often difficult to because most costs, like staff’s salaries, are *indirect*, meaning they are not allocated to a specific activity. To address this, TDABC uses data about the number of units produced, the activities involved, and the time required to complete each activity to *drive* the allocation of indirect costs to the unit. Doing so requires generating a *cost-driver*—in this case, the per-hour value of staff’s time based on their salary and benefits.

For example, if utilization management completes 100 pre-certifications for inpatient admission every year (units) and each pre-certification requires 0.25 hours of nurses’ charting (activity), and each hour of a nurses time is worth $50, the cost of staff time to compete those pre-certifications is $1250 (100 * 0.25 * 50). This cost should be summed with any *direct* costs (e.g. the phone bill for the call) to estimate the cost of completing the task.

Applying TDABC to the administrative tasks of interacting with Medicaid payers required collecting data about the frequency of tasks (e.g. phone calls, documentation, appeals), compiling staff salary and benefit data to generate cost drivers, and then surveying staff about the time required to complete various activities. When reliable unit data was not available, costs were determined using a more general form of Activity-Based-Costing (ABC) whereby staff were surveyed directly about their time-allocation to Medicaid-specific tasks.

Results of this administrative costing project are presented throughout this report and in Appendix C.
generated an additional 16 hours a day of work within the department. 7% of these authorization requests went on to be denied by the payers, prompting additional work throughout the peer-to-peer and written appeal process.

Interacting with MCOs through this pre-certification process is known to generate significant administrative costs. These costs, however, are difficult to measure because interactions are distributed across staff and departments. Moreover, the indirect costs of staff time devoted to interacting with MCOs is not specifically allocated. To date, the UIHC’s estimates of cost are at a departmental level and are gross approximations based on added Full Time Equivalents (FTEs). Such cost estimates disguise changes in the workload within each department and do not account for the shift in time-allocation away from other tasks. Although the cost of these interactions was not calculated, they represent a real cost of the transition to managed care.

In order to estimate the total cost of interacting with MCOs, an administrative costing subproject was designed to apply a tool called time-driven-activity-based-costing (TDABC) in order to sum both the direct and indirect costs of interactions with MCOs across departments (see description and Appendix C).²⁰

Using TDABC, the additional yearly cost of interacting with MCOs within Utilization Management, compared to the cost of interacting with Medicaid payers under the traditional Medicaid system, is estimated to be: $546,979.

Patient Billing and Access

Similar to Utilization Management, a variety or pre-authorizations are centralized under the office of Patient Billing and Access, a division of Patient Financial Services. Patient Billing and access manages pre-authorizations for: radiology services across all clinical departments; ambulatory procedures for the Center for Disabilities & Development, Neurology, and Otolaryngology departments; and ambulatory behavioral health services for the Center for Disabilities & Development (the Psychiatry department manages its own pre-authorizations for behavioral health and other ambulatory psychiatric services).

Based on staffing changes and surveys of time-utilization, the additional yearly cost of interacting with MCOs within Patient Billing and Access, over and above the cost of interacting with Medicaid payers before the transition to managed care, is estimated to be: $409,810.

Clinical Departments

Each clinical department is responsible for pre-authorizations that have not been centralized under Utilization Management or Patient Billing and Access. The cost of interacting with MCOs is predicted to be especially high in Orthopedics, Otolaryngology, Ophthalmology, Surgery, and Neurosurgery. The analysis for these departments is still pending but is expected to be smaller than Utilization Management or Patient Billing and Access. Preliminary analysis has been completed for the Psychiatry Department, Infusion Clinic, and Orthopedics Department (See Appendix C).
Together with Utilization Management and Patient Billing and Access, the added cost of completing prior authorizations is estimated to be at least $1,042,635.
Billing and Payment Collection

Billing and payment collection are two distinct activities housed in the domain of Patient Financial Services (the billing department). Billing begins at the outset of a patient encounter, when clinicians and staff begin medical documentation and assigning Current Procedural Terminology (CPT) codes for various diagnoses and health services. If the encounter is inpatient, the patients’ admitting diagnosis determines the Diagnostic Related Group (DRG) under which the hospital will be reimbursed (DRGs are a type of bundled payment that covers the entirety of services during that patient’s inpatient stay). If the encounter is outpatient, the provider documents services rendered and bundles the associated charges in an invoice that is sent to the payer. Whether the encounter is inpatient or outpatient, each encounter actually generates two invoices: one for hospital billing (HB) and one for professional billing (PB). Those invoices may be approved or denied by the payer, either in whole or in part. Reasons for denial include insufficient documentation, untimely filing, services outside the scope of care for the provider, dispute over the member’s enrollment status or benefit eligibility, dispute over the provider’s enrollment with the payer, and failure to obtain required prior authorizations. If a charge is denied, the payer returns the claim to the provider, indicating the denied portions of the claim together with an automatically generated explanation of why the claim was denied. There is a standard codebook for reasons for denial, but MCOs often use their own denial codes which can be nonspecific; for example, denied for “medical documentation” or “denied per policy.” Once a claim is denied, the provider typically calls the payer to inquire about the root cause. Based on what information is shared, the provider may decide to append more information and resubmit the claim to the payer. The provider may also request that the payer reprocess the denial or deliberate with the payer about whether the denial was appropriate.

Figure 4. Claims Appeal Workflow. After a patient is discharged, the charges associated with that encounter are bundled into a claim that is submitted to the MCO. The MCO processes the claim and then approves or denies the claim. If denied, the claim is returned to the provider and the provider may decide whether to edit and resubmit the claim.
These interactions typically occur over the phone, alongside a potentially infinite cycle of resubmitting and reprocessing the claim (see diagram). When a claim is submitted but unpaid, the hospital assigns that claim to accounts receivable (A/R), where the claims is monitored based on the number of days the claim is outstanding. From the hospital’s perspective, accounts receivable represents claims on which the hospital expects to collect payment. Once the payer denies a claim, however, the payer does not recognize these claims as future outlays. This discrepancy between payer and provider led UIHC to create an alternative “issues log” of claims that it believed were inappropriately denied and share it with the MCO. Through weekly teleconference calls, the accounts receivable team and members from the MCO review the issues log to try to resolve claims disputes.

Post-managed Care Denial rates

After the transition to managed care, UIHC noted a spike in denials across medicaid payers (see Figure 5). From March to April 2016, the average hospital billing (HB) denial rate more than doubled, from 19% to 46%. This rise in denials was driven by denials for “coordination of benefits,” “needs review,” “authorizations,” and “timely filing.” Coordination of benefits is the term used to describe disputes over shared liability when a patient has coverage with more than one insurer. In the case of Medicaid managed care, these claims are often denied when the MCO is the secondary payer but the member has another commercial plan as their primary payer. “Needs Review” notably drove the initial spike in denials.

Figure 5. Hospital Billing (HB) Denial Rates to Invoices, by Discharge/Service Period. Denial rate is the number of claims denied, in whole or in part, over the number of claims submitted. Claims are organized by the month the patient was discharged, not the month the claim was submitted. The gross HB denial rate more than doubled after the transition to managed care but gradually returned to levels comparable to before the managed care transition.
The initial spike in denials was driven by a rise in denials for coordination of benefits, needs review, authorizations, and timely filing.

The initial spike in denial rates can also be seen in the first-pass denial rates to the amount charged (Figure 6). Comparing HB and PB charges, it is clear that the initial spike was focused on the hospital billing. After the initial period, the first-pass denial rate actually decreased to levels at or lower than those before managed care.

Although the rate of first-pass denials has now declined below pre-managed care rates, the work of appealing and resubmitting the initial denials has continued long past the initial transition. UIHC has continued to resubmit and reprocess denied claims multiple times, generating significant work for the provider (see Figure 7). Appealing these early first-pass denials has been essential in order to sustain a reasonable Medicaid collection rate. Doing so, however, has drawn significant resources from multiple divisions of Patient Financial Services.

Figure 6. Hospital Billing (HB) and Physician Billing (PB) First-Pass Denial Rates to Amount Charged, by Discharge/Service Period. Bars represent percent of the amount charged that was denied in the first pass of the HAR. Note the spike in denial rate in HB charges in the months after the transition.

Figure 7. Hospital Billing (HB) Denial Rate to Invoices and Charges, by Post/Accept Period. Denial rate is the number of denials in the post/accept period over the number of invoices or charges submitted in that posting period. Because an invoice can be resubmitted multiple times, an invoice be submitted and...
denied in multiple periods. This iterative process has generated a significantly higher workload in Patient and Financial Services, evidenced by the higher denial rate to invoices and charges in any period. HB denial rates to invoices increased, on average, from 19% to 31% in each period. HB denial rates to charges nearly doubled, from 1.6% to 2.9% in each period.

Accounts Receivable

Accounts receivable is responsible for monitoring and appealing unpaid claims. Based on surveys of time-usage, the yearly additional cost of adjudicating Medicaid claims after the managed care transition is $879,539.

Revenue Integrity

Revenue integrity is charged with monitoring the operational efficiency of the revenue cycle. To do this, Revenue integrity continually evaluates the health system’s billing practices, reimbursement rates, and compliance with relevant rules and regulations. In the case of the early denials after the transition to managed care, revenue integrity would be monitoring “revenue leakage” due to the difference between managed care payment collection and the expected reimbursements based on the health system’s prior experience. Based on surveys of time-usage, the additional yearly cost of monitoring payments under Medicaid Managed Care is $227,444.

The additional costs in Patient Billing and Access—although it is housed within Patient Financial Services—was described under the costs of prior authorizations because these activities centered around obtaining pre-authorizations for radiology and other services. Patient Access Management and Coding Integrity Division did not report changes in their workflows due to Medicaid Managed Care.

Together, the added cost of billing and appeals in Accounts Receivable and Revenue Integrity is estimated to be $1,106,982. There is a general perception in UIHC that this cost is due to a continued flow of new denials. However, this analysis suggests that the majority of this added work is associated with appealing claims that were denied in the first six to eight months of the managed care transition.
The Administrative Cost of Interacting with MCOs (X)

Together, the “added costs” of interacting with MCOs in each department can be summed to estimate the total administrative burden of managed care for the provider. A portion of these costs are in the form of new hires and reassignments of staff. The majority of these costs, however, represent a “shift” in resource utilization away from other tasks and payers. A portion of this added cost were accommodated by departments working closer to their operational capacity. Every department also makes efficiency gains each year that opens up extra capacity. Because of the advent of Medicaid Managed Care, that extra capacity has likely also been redirected to working with MCOs.

In sum, the additional cost of interacting with Medicaid payers after the transition to managed care was $2.1 million per year. This number is predicted to be a low-end approximation because most clinical departments were not surveyed and yet many authorization and payment processes are still scattered among the clinical departments. Improving the accuracy of this number will require broader application of more specific time-use studies.

Rounding up to account for costs not captured in this analysis, this added $2.1 million administrative cost translates to approximately 1% of Medicaid revenues (hospital and professional). Standardizing processes that would reduce this administrative burden. The state Medicaid agency could, for example, require standard credentialing, authorization, and billing
procedures across MCOs, or review the appropriateness of MCO prior authorizations. These and other proposals are considered later, in Legislative Priorities.
Supplemental Payments

In addition to FFS payments for services rendered, UIHC receives a variety of supplemental payments. These include Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL), and Graduate Medical Education (GME) payments. These payments are designed to supplement UIHC for uncompensated costs, such as providing care for prisoners and indigent patients, training future medical providers, and fulfilling other roles, as needed, as a state institution. Transitioning to managed care set in motion certain changes to these payments. In particular, the May 6, 2016 Medicaid and CHIP Final Rule triggered changes to pass-through payments—in particular, UPL payments—which are paid by the state through MCOs to the provider. These pass-through payments are to be phased out due to Medicaid managed care regulations (GME payments are specifically excluded).21

UPL Payments

The Upper Payment Limit is a cap on aggregate statewide Medicaid fee-for-service spending set by the Federal Government. Because Medicaid is administered by states but jointly funded by the federal government, the federal government wanted to create an upper bound on how much states could spend using federal dollars. The cap varies by provider type (inpatient facility, outpatient facilities, and physicians) but within each category, a state cannot pay providers more than they would have been paid by Medicare for the same services. Above that upper bound, Medicaid reimbursements are not eligible for the federal match. States typically set their Medicaid rates to reimburse providers less than Medicare, so the UPL is rarely met. Federal regulations allow states to distribute additional “UPL payments”, however, in order to take advantage of the federal match between current Medicaid reimbursement levels and the UPL cap. The state can distribute these UPL payments however it chooses.22 States typically use UPL payments to support state-owned or safety-net hospitals.

Throughout the managed care transition, UIHC received and continues to receive UPL payments on a scale much larger than the administrative cost of interacting with MCOs. These UPL payments were originally included in IME’s FFS payments to the provider. After the transition, they were paid through MCO’s FFS payments. In the May 6, 2016 Final Rule (81 FR 27587 through 27592) CMS noted that “section 1903(m)(2)(A) of the Social Security Act (the Act) requires that capitation payments to managed care plans be actuarially sound”. They interpreted this requirement to mean that payments under a managed care contract must align with the benefits/services described by the contract. Thus, UPL and other pass-through payments were excluded. Recognizing this would have abrupt financial effects for many providers, CMS decided to smooth the transition and “provide states and managed care plans with adequate time to design and implement payment systems that link provider reimbursement with services covered under the contract or associated quality outcomes.” On January 17, 2017, CMS issued a new Final Rule that updated limits on pass-through payments (such as UPL) in Medicaid managed care, effective March 20, 2017.23 As finalized, § 438.6(d)(2) and (3) provided a 10-year transition period for hospitals (terminating in July 1, 2027) and a 5-year transition period for physicians and nursing facilities (terminating July 1, 2022). The transition period for hospitals is a 10% annual phase-out. The transition period for Physicians is
not a phase-out but a cliff. Hospital UPL payments are only 2% of UIHC’s UPL payments, making Physician UPL payments, and the fiscal cliff in 2022, the important deadline.

Under federal guidelines, UPL payments can be transformed into enhanced fee schedules or value-based payment systems, but these payments must be contractual and be part of the actuarial calculation. In other words, the payments have to be somehow tied to services, utilization, or outcomes.

States interested in preserving support for UPL hospitals but that do not have the capacity to transform UPL payments into value-based payments are considering a variety of alternatives (see Milliman White Paper by Gaffner et al). Primary among these alternatives is replaces UPL dollars with DSH and GME payments.

DSH Payments

Disproportionate Share Hospital (DSH) payments are another form of supplemental payment designed to offset the costs of uncompensated care and improve access for Medicaid patients. Like UPL payments, DSH payments are jointly funded by state and federal governments. And similar to the upper payment limit, federal regulations cap the amount of Medicaid DSH payments.

To fund the state’s share of DSH payments, states often charge a provider tax or require providers to make an intergovernmental transfer (IGT) into a DSH pool. The federal government matches the funds in that pool and the state then distributes those funds to hospitals, up to the federally designated Hospital Specific Limit (HSL). The HSL is audited by the government every year, and providers must pay back any difference.

DSH payments themselves are not affected by the managed care transition. But the DSH funding process and the HSL are important because both DSH and GME payments contribute to the hospital’s allowed payments under the HSL. Especially if DSH and GME payments are used as a way to replace UPL payments, a hospital may quickly max out their UPL allotment.

GME Payments

GME Payments are designed to compensate teaching hospitals for the costs of training medical residents. GME payments currently amount to approximately $16.5 million yearly revenue for UIHC.

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Only Broadlawns and UIHC receive DSH payments in Iowa. Broadlawns, however, is in a different DSH pool. Broadlawns and potentially other Des Moines metro hospitals pay a county provider tax that is then matched and returned to Broadlawns. UIHC pays into a different DSH pool through intergovernmental transfer (IGT) and those dollars are then returned to UIHC after the federal match.
GME payments, as previously mentioned, are excluded from the pass-through payment regulations of the May 6, 2016 Final Rule. The payment methodology for GME, however, has changed under managed care—confusing and creating uncertainty in these payments.27

As opposed to about half of states which use Medicare’s prescribed methodology to calculate GME payments, Iowa uses its own, unique, methodology to allocate GME funds. UIHC is part of a “state GME pool” that’s payout is recalculated every three years in tandem with IME’s rebasing of Medicaid rates. As of January 1, 2016, approximately 95% of UIHC’s GME funding is supposed to collected as pass-through payments from MCOs. To date, however, UIHC has routinely collected only approximately 91% of those dollars. UIHC can currently compensate for this difference because it is able to receive GME funding (up to its GME allotment) through FFS payments made by the state. This compensation has only been possible, however, because:

1) Approximately 10,000 AmeriHealth members moved to IME after AmeriHealth’s exit, bolstering the number of UIHC’s Medicaid population covered by state FFS.
2) UIHC enrolls many new Medicaid members, who used to be retroactively covered for 3 months, and who are prospectively covered for by the state until they select or are assigned to an MCO.

With the removal of retroactive coverage, there is rising uncertainty that UIHC can continue to achieve its full GME revenue targets, since many of those new Medicaid members are not FFS now but rather self-pay.

Supplemental Payments’ Potential Future Costs

While the administrative costs of interacting with MCOs is high and the collection rate from MCOs is decreasing, the potential future costs to the health system due to changes in supplemental payments are much larger. Hospital UPL payments, alone, represent a disproportionalate risk, beginning in 2022. And together, the changes in Physician UPL payments, DSH, and GME payments raise that risk even higher. Devising a strategy to protect supplemental payments or replace them with other funding sources is critical to the financial integrity of the health system.
Legislative Priorities

At the beginning of the Spring 2018 legislative session, intense political pressure to make changes to Medicaid managed care system presented an opportunity to advocate for changes to Medicaid rules regarding payment and authorization requirements. This section summarizes potential legislative tools that address the problems of delayed payment and frequent prior authorizations in Medicaid Managed Care. These tools and recommendations are designed remain relevant through this and future legislative sessions.

To orient the reader, recall that the transition to managed care created a burden on providers due to excessive prior authorizations and unprecedented delays in payment. These problems are not unique to Iowa nor to managed care, but they are often pronounced in states undergoing a managed care transition. The state of Kansas, for example—where both Amerigroup and United Healthcare also operate—recently passed comprehensive managed care reforms in 2017 (KS HB2026).

To assemble legislative options for how to improve prior authorizations and prompt payment in Iowa, we enlisted the assistance of the American Hospital Association, which disseminated a query to AHA members across the country to ask for examples of successful Managed Care legislation. We collected and reviewed legislation from seven states (see list of bills). We then categorized the provisions within each bill and identified fourteen distinct “tools” that the bills employed. To this list, we added ten novel tools that were generated through conversations with UIHC clinical and administrative departments. Rationales and examples of legislative language (where available) were appended to each tool. The tools were then graded by five criteria and ranked based on their criteria-weighted score.

Detailed descriptions and examples of legislative language are available in Appendix D.

Bills

- **Georgia “Prompt Payment Statute”** (Standard rule in §33-24-59.14)
- **Nebraska “Health Care Prompt Payment Act”** (Revised Statute 44-8001).
- **Illinois State Prompt Payment Act** (30 ILCS 540) and Insurance Code.
- **Michigan “Timely claims processing and payment procedure”** (MCL 400.111).
- **California Health and Safety Code** (HSC § 1371 through 1371.36.)
- **Louisiana “Prompt Payment of Claims”** (§3511)

These bills were assembled with the assistance of the American Hospital Association.
Legislative Tools

Legislative tools can be categorized into five types: tools that apply to Prompt Payment, Supplemental Payments and Rate Changes, Appeals and External Review, Logistics and Records, and Prior Authorizations.

When reviewing these legislative options, it is important to consider that:

- **Legislation that refers only to “clean claims” or “proper bills” is insufficient** because delays in payment are often caused by disagreement about whether the claim is “clean.”
- **A combination of tools will be required** in order to guarantee timely and accurate payment. **Holding MCOs accountable requires oversight through audit and appeals.**
- MCO contracts detail some provider rights. **Current legislative advocacy should focus on what new standards and authorities need to be created.** Continued advocacy will be required to shape the regulatory details.

Prompt Payment

**Set a time limit by which the MCO must pay a claim or respond with an itemized list of the information needed to process the claim.**

Timely payment guidelines exist in provider-MCO contracts, however there is currently no standard by when MCOs must process, pay, or respond to a claim, and there are insufficient penalties for failing to comply. What guidelines exist are written into contracts and vary by MCO. In addition, when an MCO denies a claim, the MCO’s response is often unclear or nonspecific (e.g. “denied per policy”). **It is important the MCO responses be itemized and contain specific instructions** about why a claim was denied and what information is needed in order to process it.

- “When all of the listed documents or other information needed to process the claim have been received by the insurer or administrator, the insurer or administrator shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the facility or health care provider claiming payments under the plan the insurer’s or administrator’s reasons for such denial.” (Georgia §33-24-59.14)

- “The secretary shall require any managed care organization…provide documentation to a healthcare provider when the managed care organization denies any portion of any claim for reimbursement submitted by the provider, including a specific explanation of the reasons for denial and utilization of remark codes, remittance advice and health insurance portability and accountability act of 1996 standard denial reasons.” (Kansas HB2026)

If possible, it would also be ideal if MCO responses used the same language.

**The secretary shall standardize the coding and format of responses across MCOs.**

**Set a time limit by which the MCO must resolve appeals.**

MCO claims processing systems have programming errors that cause systemic over and underpayment of provider claims. If a provider identifies a claims programming or
provider data load error that causes incorrect denials or inaccurate payment resulting in either over or underpayment, there shall be timely correction of such errors.

- “Each managed care organization, within 60 calendar days of receiving an appeal request, provide notice and resolve 100% of provider appeals, subject to remedies, including, but not limited to, liquidated damages if provider appeals are not resolved within the required time.” (Kansas HB2026)

Charge the MCO interest or a penalty on claims not paid by a given time point.

Delayed payment imposes a cost on providers and a benefit to payers because of the decreasing net present value of the payment due to inflation. Without legislating an interest rate on claims, the interest rate is, by default, 0%.

- “An insurer that fails to pay, deny, or settle a clean claim in accordance with the time periods set forth… shall pay interest at the rate of twelve percent per annum on the total amount ultimately allowed on the claim…” (Nebraska 44-8005)
- “If an uncontested claim is not reimbursed by delivery to the claimants’ address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum.” (California HSC § 1371)

Charge the MCO interest or a penalty on claims incorrectly denied or underpaid.

Claims found to be incorrectly denied or underpaid (through the appeals process or audit) should be subject to a higher interest rate or a penalty because of the administrative burden appealing of appealing those claims. This will create an incentive for timely correction of incorrect payments and denials. In Iowa, providers are still dealing with incorrect payments and denials that are 9-18 months old.

- “For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted.” (Georgia § 33-21A-7)

Require the MCO to pay any undisputed portion of a claim.

This language already exists in current MCO contracts but would be prudent to have coded in law.

- “Where the insurer or administrator disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer or administrator in accordance with this chapter.” (Georgia §33-24-59.14)

Supplemental Payments and Rate Changes

Require MCOs to pay interest on “pass-through payments” (Physician Supplemental payments and GME payments).

MCOs make State University of Iowa Physician Supplemental payments in capitated payments that are required to be no later than the 15th day of the month. There is no penalty or interest charged, however, if the payment is late.
Set a time limit on retroactive rate decreases by IME

Any proper resolution achieved through the aforementioned statutes is jeopardized by retroactive rate changes by IME. Examples include rebase delays, Addendum B update delays, cost containment or other payment changes and delays on the PMPM rates.

- Retroactive rate decreases shall not extend further than 3 months from the time of final rate decisions.

Appeals and External Review

Give providers the right to appeal disputes to an independent, third-party for external review and Standardize the appeals process for disputed claims

Consistent with the commercial insurance market, providers should have the right to appeal an MCO decision and request an external review by an independent third party:

- “On and after January 1, 2020, a provider who has been denied a healthcare service to a recipient of medical assistance or a claim for reimbursement to the provider for a healthcare service rendered to a recipient of medical assistance and who has exhausted the internal written appeals process of a managed care organization providing state Medicaid services pursuant to a contract with the Kansas program of medical assistance shall be entitled to an external independent third-party review of the managed care organization’s final decision.” “The secretary shall develop…a grievance, appeal and state fair hearing process that complies with applicable federal and state statutory and regulatory procedure requirements, including any statutory remedies for timely resolution of grievances, appeals and state fair hearings.” Details in bill. (Kansas HB2026)

- “The commissioner shall establish an external review procedure…” Details in bill. (Michigan 400-111)

This right to an independent, third-party, external review would be integrated into a standardized appeals process, consistent with state and federal fair hearing processes.

Allow provider to bundle claims during the appeals process.

This practice is permitted under current contracts and norms but would be prudent to have coded in law.

- “A care management organization shall allow providers to consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims” (Georgia § 33-21A-7)

Set a time limit after which claims default to external review or mediation or nonbinding arbitration

Because many claims remain in dispute between the payer and provider, regarding whether or not they compose a “clean claim,” it is logical to set a maximum time limit by which a claim must be processed or rescinded, after which the claim automatically defaults to a predefined appeals process or binding arbitration.

- “If a claim is in dispute for longer than 6 months from the time it is submitted, that claim will advance to external review per the predefined appeals process.”
Create a regular, independent audit of claims payment, paid for by the MCOs.

The integrity of the Medicaid system depends on a strong and rigorous state Medicaid agency with the capacity to guarantee the accuracy of payments.

- “The secretary shall procure the services of an independent auditor for the purpose of reviewing, at least once per calendar year, a random sample of all claims paid and denied… Each managed care organization and each managed care organization’s subcontractors shall be required to pay any claim that the independent auditor determines to be incorrectly denied. Each managed care organization and each managed care organization’s subcontractors may also be required to pay liquidated damages… Each managed care organization and each managed care organization’s subcontractors shall be required to pay the cost of audits conducted under this subsection.” (Kansas HB2026)

Require DHS to investigate and penalize insurers for patterns of inaccurate payment, & allow providers to request an independent, external audit of MCOs.

Require DHS to investigate and penalize insurers for patterns of “unfair payment.” The investigation would be paid for by the insurer.

- “The director shall compile a record of notices, and if it appears to the director that an insurer, or a third party working on behalf of an insurer, may be engaged in an unfair payment pattern or that an insurer has filed a prompt payment act compliance statement that the insurer knows or has reason to know is false, the director may examine and investigate the affairs of such insurer or third party.” (Nebraska 44-8008)
  - “A provider subject to such patterns of unfair payment may also, if able to produce evidence of unfair payment patterns, request such an investigation. The secretary will develop standards which, if met, require such an investigation to proceed.” (Nebraska 44-8008)

Logistics and Documentation

Require MCOs to maintain an electronic website to submit and adjudicate claims.

All MCOs currently maintain a website where providers can submit and view claims, however some MCOs do not allow providers to submit “claim disputes”, “reconsiderations”, and “appeals” on their website. This process is standard among other commercial payers. This lack of functionality means that providers must contest claims over the phone and maintain a separate log of a claim’s status, rather than participating in an open and shared record.

- “Each care management organization shall maintain a website that allows providers to submit, process, edit, rebill, and adjudicate claims electronically.” (Georgia § 33-21A-7)
  - The website must allow providers to request reconsiderations and submit provider inquiries and claim disputes.

Standardize Provider Enrollment (in Medicaid) and Credentialing (with MCO).

- “The secretary shall develop… A standardized enrollment form and a uniform process for credentialing and re-credentialing healthcare providers who have signed contracts or participation agreements with any such managed care organization” (Kansas HB2026)
Require MCOs to load providers by a certain time point.

Failure to load providers in a timely manner leads to payment issues when providers begin to submit claims but are not loaded in the system.

Require MCOs and DHS to provide paid claims and encounter data reports to the provider upon request.

MCOs already submit paid claims report data regularly to the state, however those reports are not shared with providers. This data is needed by providers to produce required Medicaid Cost Reports submitted to the state. The providers’ paid claims data needs to be shared timely in order to verify accuracy and allow for budgeting and forecasting.

- MCOs must provide a customized paid claims (encounter) data report to the provider within 60 days upon request.
- “Upon request by a participating healthcare provider under the Kansas medical assistance program, the secretary of health and environment shall provide accurate and uniform patient encounter data that complies with the federal health insurance portability and accountability act of 1996 and applicable federal and state statutory and regulatory requirements, including, but not limited to: the Managed care organization claim number; Patient Medicaid identification number; Patient name; Type of claim; Amount billed by revenue code and procedure code; Managed care organization paid amount and paid date; and Hospital patient account number”

Prior Authorizations

Eliminate unnecessary prior authorization for ICU admissions.

The purpose of MCO authorization of inpatient admissions is to ensure that all admissions are medically necessary. The amount of documentation and review is currently burdensome. Certain levels of care within hospitals are obviously medically necessary and authorization is unnecessary, such as admissions to Intensive Care Unit level of care. ICUs require evaluation by two clinical teams for admission (the admitting team and the ICU team before admission because it is a limited resource. This creates an inherent check and balance against inappropriate admission. ICUs have much higher cost to operate and staff and are always a limited availability in a hospital. The current DRG system, which pays a fixed per diem based on the diagnosis also provides a natural disincentive to admit to ICU if the patient does not need that level of care because of the higher expense.

- Exempt Inpatient admissions to Intensive Care Unit level of care from MCO inpatient authorization.

Allow more time for providers to complete authorization for inpatient admissions (2 business days).

Providers are only given 24 hours from the time of admission to request MCO authorization of the inpatient admission. MCOs have to issue approval or denial within very time timelines per the contracts or face financial penalties. Often the clinical information and documentation is not available in 24 hours to provide to the MCOs, and given the MCO contracts, they are forced to issue denial. The next step after Denial is ‘peer to peer’ review, which requires the provider physician and the MCO physicians to speak on the phone, which is a very time consuming process for physicians. This process could be improved by adding more time for the provider to provide information and by offering a second step
option before requiring peer to peer (and reduce the eventual number of peer to peer consultations).

- **Providers shall have 2 business days to provide information for authorizations of inpatient admissions.**

- **If authorization is denied, providers may request reconsideration to provide further information within 2 business days.**

**Create a fee for completing a prior authorization**

Prior authorizations represent a significant tax on provider staff and resources. To address this, the Provider should be permitted to charge the MCO a fee in order to recover the lost productivity due to interacting with the MCO.

- **The MCO will be charged a fee for every prior authorization, proportionate to the lost productivity of the provider due to completing the prior authorization process.**

**Standardize the deadlines for filing clinical documentation, submitting appeals, and completing peer-to-peer.**

MCOs vary in the times they prescribe.

- **All MCOs will allow at least 7 days for the provider to complete pre-certification for unscheduled admission.**

**Require MCOs to aggregate Pre-certifications and Pre-authorization denials in one communication a day**

Utilization management currently receives five emails a day from some MCOs—each with its own deadline 24 hours from the time of receipt. This creates confusion and unnecessary logistical burden for utilization management.

**Allow providers to request a reconsideration of prior authorization denial before having to submit written appeal or complete a peer-to-peer.**

Under the current system, providers shoulder the initial burden of proof when an authorization is denied. When an authorization is denied, the provider must decide whether to pursue an appeal, often requiring a lengthy literature review or peer-to-peer process. By creating an interim step whereby, the provider can request that the MCO reconsider its denial, there is an opportunity to avoid a lengthy appeal process for both the provider and the MCO.

**Align FDA approved medications with the IME and MCO formularies.**

Standardizing the formularies and indications for therapy between the state and the MCOs would help eliminate confusion over what was covered and when.

**Carve out high-cost medications from the state’s managed care contracts and create a cost pool for covering those medications.**

If the state reclaimed responsibility for administering high-cost medications, providers could avoid the laborious process of appealing these authorizations with MCOs. Instead, providers would go directly to the state for authorization and payment of high-cost medications, such as Spinraza and Sovaldi.
Criteria

The previous legislative tools were graded using the following criteria:

- **Financial Impact.** Financial Impact considers how the legislation affects the expected collection rate, revenue, expenses, and workload due to prior authorizations. Financial Impact was weighted at 30% due to the imperative to improve collections and decrease the administrative burden of interacting with MCOs.

- **Operational Feasibility.** Any contractual agreement must fit within the operational and technological capabilities of UIHC. Various legislative tools either relieve the provider of operational tasks, change workflows, or require new operational capacity. Operational Feasibility was weighted at 20%.

- **Political Feasibility.** Political feasibility evaluates the legislative tool’s chances of passing through both houses of the legislature and the governors’ desk considering the major parties lobbying for and against it and the coalition of supporters that could be assembled. Any strategy must acknowledge its effect on political capital and take into account collateral effects on UIHC’s other priorities. Political Feasibility was weighted at 30% because of the importance of passing legislation.

- **Potential Risk.** Some legislative tools harbor potential financial or political risks depending on the changing budgetary climate and competitive forces in the market. Potential Risks were weighted at 10% because of the uncertainty surrounding them.

- **Novelty Compared to Other Payer Contracts.** Considering existing contract language and compliance. Novelty was weighted at 10% because of its direct effect on (and thus collinearity with) political feasibility.

- **Impact on Patient Care.** UIHC is committed to “providing patient-focused care — available to every person, around the clock — in an environment devoted to innovative care, excellent service, and exceptional outcomes.” The effect of these payment processes on patient care is difficult to quantify so was not calculated in this analysis. Nevertheless, the financial solvency of the institution is integral to sustaining its mission and so the financial impact of these processes undoubtedly affects UIHC’s ability to execute that mission.

The results of this analysis are presented in the following table and in Appendix D. Appendix D contains detailed descriptions of the political and financial risks associated with each proposal. Appendix D is not distributed in the public report.
## Legislative Priorities Grid

<table>
<thead>
<tr>
<th>Legislative Tools and Grading</th>
<th>Financial Impact</th>
<th>Operational Feasibility</th>
<th>Political Feasibility</th>
<th>Potential Risk</th>
<th>Novelty to Contracts</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prompt Payment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Set a time limit by which the MCO must pay a claim or respond with an itemized list of information needed</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Yellow]</td>
<td>[Yellow]</td>
<td>14</td>
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<tr>
<td>Set a time limit by which the MCO must resolve appeals.</td>
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<td>[Green]</td>
<td>[Yellow]</td>
<td>[Green]</td>
<td>[Green]</td>
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<tr>
<td>Charge the MCO interest or a penalty on claims not paid by a given time point.</td>
<td>[Yellow]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Yellow]</td>
<td>10</td>
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<tr>
<td>Charge the MCO interest or a penalty on claims incorrectly denied or underpaid.</td>
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<td>[Green]</td>
<td>[Yellow]</td>
<td>[Green]</td>
<td>[Yellow]</td>
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<tr>
<td>Require the MCO to pay any undisputed portion of a claim.</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
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<tr>
<td><strong>Supplemental Payments and Rate Changes</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Require MCOs to pay interest on “pass-through payments” (Physician Supplemental payments and GME payments).</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Yellow]</td>
<td>[Yellow]</td>
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<tr>
<td>Set a time limit on retroactive rate decreases by IME</td>
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<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
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<tr>
<td><strong>Appeals and External Review</strong></td>
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</tr>
<tr>
<td>Give providers the right to appeal disputes to an independent, third-party for external review</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Yellow]</td>
<td>[Yellow]</td>
<td>9</td>
</tr>
<tr>
<td>Allow provider to bundle claims during the appeals process.</td>
<td>[Yellow]</td>
<td>[Yellow]</td>
<td>[Yellow]</td>
<td>[Yellow]</td>
<td>[Yellow]</td>
<td>3</td>
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<tr>
<td>Set a time limit after which claims default to external review or mediation or nonbinding arbitration.</td>
<td>[Yellow]</td>
<td>[Yellow]</td>
<td>[Yellow]</td>
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<td>[Yellow]</td>
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</tr>
<tr>
<td>Create a regular, independent audit of claims payment, paid for by the MCOs.</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>9</td>
</tr>
<tr>
<td>Allow providers to request an independent, external audit of MCOs.</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>[Green]</td>
<td>11</td>
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### Logistics and Documentation

<table>
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<tr>
<th>Requirement</th>
<th>Score</th>
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<tbody>
<tr>
<td>Require MCOs to maintain an electronic website to submit and adjudicate claims.</td>
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</tr>
<tr>
<td>Standardize Provider Enrollment (in Medicaid) and Credentialing (with MCO).</td>
<td>5</td>
</tr>
<tr>
<td>Require MCOs to load providers by a certain time point.</td>
<td>1</td>
</tr>
<tr>
<td>Require MCOs and DHS to provide paid claims and encounter data reports to the provider upon request.</td>
<td>4</td>
</tr>
</tbody>
</table>

### Prior Authorizations

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliminate unnecessary prior authorization for ICU admissions.</td>
<td>16</td>
</tr>
<tr>
<td>Allow more time for providers to complete authorization for inpatient admissions (2 business days).</td>
<td>6</td>
</tr>
<tr>
<td>Create a fee for completing a prior authorization</td>
<td>13</td>
</tr>
<tr>
<td>Standardize the deadlines for filing clinical documentation, submitting appeals, and completing peer-to-peer.</td>
<td>7</td>
</tr>
<tr>
<td>Require MCOs to aggregate Pre-certifications and Pre-authorization denials in one communication a day</td>
<td>4</td>
</tr>
<tr>
<td>Allow providers to request a reconsideration of a denial before submitting an appeal or completing peer-to-peer.</td>
<td>17</td>
</tr>
<tr>
<td>Align FDA approved medications with the IME and MCO formularies.</td>
<td>5</td>
</tr>
<tr>
<td>Carve out high-cost medications from the state’s managed care contracts.</td>
<td>9</td>
</tr>
</tbody>
</table>
Legislative Priorities

Based on the grading and weights assigned to the five criteria, legislative priorities should include:

- **Require the MCO to pay any undisputed portion of a claim.**
- **Set a time limit on retroactive rate decreases by IME.**
- **Allow provider to bundle claims during the appeals process.**
- **Require MCOs to maintain an electronic website to submit and adjudicate claims.**
- **Standardize Provider Enrollment (in Medicaid) and Credentialing (with MCO).**
- **Require MCOs to load providers by a certain time point.**
- **Require MCOs and DHS to provide paid claims and encounter data reports to the provider upon request.**
- **Allow more time for providers to complete authorization for inpatient admissions (2 business days).**
- **Require MCOs to aggregate Pre-certifications and Pre-authorization denials in one communication a day.**
- **Align FDA approved medications with the IME and MCO formularies.**

Again, these priorities do not represent the tools that would have the largest effect on relieving the administrative burden of interacting with MCOs. Rather, they are the most viable tools that are predicted to secure reliable relief. The reader will notice that many of these priorities fall in the category of “logistics and documentation”, which is nearly analogous to “lack of coordination”—one of the three causes of high administrative costs in health care identified by Cutler and Ly in section “Reasons for High Administrative Costs”. It is not surprising that these proposals are more politically feasible because they represent “pure” efficiency gains that generate value for almost every actor.

As depicted in the legislative priorities grid, many other legislative proposals are hindered by a lack of political feasibility. Improving the political feasibility of these proposals requires the formation of a coalition of providers, patients, and even payers. Building such a coalition depends on recognizing the incentives, position, and powers of each of each stakeholder. Strategies for assembling such a coalition are evaluated in the next section.

**Stakeholders**

In order to improve the political feasibility of legislative proposals that address prior authorization and prompt payment, UIHC needs to align itself with the interests of the relevant stakeholders. To do so, UIHC should consider the issues of prior authorization and prompt payment separately.

**Stakeholder Map – Prior Authorizations**
The estimated additional administrative cost of prior authorizations under Medicaid managed care to UIHC is between $500,000 and $1.5 million dollars a year. The costs of prior authorizations are also salient for patients and for other providers across the state. Counter-intuitively, however, prior authorizations are also a grievance for MCOs.

The common perception is that MCOs use prior authorizations to discourage service utilization by patients and providers. By creating a complex and laborious process, people believe MCOs can discourage utilization and decrease costs. Similar to providers, however, MCOs must invest significant resources in reviewing and processing prior authorizations. If MCOs deny members’ rightful benefits, members have access to an legal process that can levy heavy penalties. And if providers’ prior authorization request is appropriate, or if, on the back end, the services prove to be medically necessary, MCOs and providers both lose money on the hassle of processing the authorization request. Especially with a provider like UIHC, which aggressively pursues authorization appeals, the interests of the provider and the MCO are aligned in eliminating this hassle.

The state, on the other hand, has neither the incentive to decrease the volume of authorizations nor to decrease the administrative cost of processing them. Before managed care, the state bore the cost of processing prior authorizations. Now, if UIHC appeals a prior authorization and eventually overturns it, then the service is clearly medically necessary and both UIHC and the MCOs are enduring the cost of the appeals process. The state is happy to keep this administrative cost on the MCO and the provider. In addition, prior authorizations are one of the reasons the state moved to managed care. As the ultimate payer for Medicaid services, the state is acting based on the theory that the fee-for-service system has generated significant waste in the volume of medical services. The state wants MCOs to “experiment with prior authorizations” as one way to innovate and compete with each other, with the expectation that this will generate more efficient care. The state is not interested in “tying their hands.”

**Stakeholder Map – Prompt Payment**

Although the state does not have the incentive to decrease the cost of verifying that a service is medically necessary, it does have the incentive to ensure that medically necessary services are promptly paid. Timely payment is important so that providers stay in the Medicaid network, rural hospitals and long-term-care centers stay in business, services are delivered, and political pressure is allayed. The state wins nothing if outlays are suspended in the pocket of the MCO.

Other providers and patients are similarly interested in supporting prompt payment. Many providers have large Medicaid patient populations, and those that do not may still want to improve access to these populations as part of their medical mission. If payments are delayed

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vi There is continued debate about whether the waste in U.S. healthcare is due to the volume or price of medical services. Recent research has supported the theory that price, not volume, is actually prime driver of healthcare spending. This is demonstrated by the fact that people in the United States have the same or fewer number of encounters with the health system as people in other countries. It is complicated, however, by the fact that people in the U.S. receive a greater number services during each encounter than people in comparative countries.28
and providers leave the Medicaid network, patients are left traveling further to access medical services or not accessing services at all.

Because of the popular perception of MCOs, the public and current legislators are interested in “holding MCOs accountable” in any way possible, including controls on prior authorizations and timely payment. Public support on these issues is time-limited, however, as other news will inevitably overtake the issue of managed care.

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Prior Authorizations</th>
<th>Timely Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>UIHC</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Providers</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>State Administration (IME)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>MCOs</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Patients</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Public &amp; Legislature</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 1. Stakeholder Alignment on Prior Authorization and Prompt Payment. Stakeholders in support of controls on prior authorizations and timely payment are indicated with a “Yes”. Stakeholders disinterested in controlling those issues are indicated with “no.” UIHC is aligned with a broad coalition of other providers, patients, and the public on both issues. The state, however, is unlikely to support controls on prior authorizations, and MCOs are unlikely to support controls on timely payment. The different between these two stakeholder maps suggests that the issues of prior authorization and timely payment should be considered separately.

Negotiation Principles & Strategy

The difference between the incentives in prior authorization and prompt payment suggests that the negotiation on these issues should be broken in two. The state is unlikely to support controls on prior authorizations and MCOs are unlikely to support controls on timely payment, so UIHC should devise a separate strategy for each.

If the state does not want to restrict prior authorizations, it is unlikely this issue can be successfully legislated. Instead, this issue can be handled in direct negotiation with the MCOs, where the interest in reducing the administrative cost of prior authorizations is mutually aligned.

Already, this strategy of cooperating with the MCOs on prior authorization proves to have some traction. One MCO agreed to extend the number of days between inpatient continued stay renewals after it was approached by utilization management and compared with other MCOs. Utilization management also had trouble contacting a specific prior authorizations team within one MCO, and now has been given a direct extension. Other efficiency gains may also be possible. Experienced managed care companies sometimes pro-rate providers based on their prior authorization approval rate. If a provider is consistently being approved or overturning denials, the MCO may consider removing prior authorizations from procedures and medications. Prior authorization efficiency can also be greatly improved by sharing a list of what services require prior authorization and what criteria are needed for approval. Providers
can then decide when to pursue prior authorization or consider other options. Lastly, MCOs are gradually improving their online prior authorization portals, which better track requests and correspondence.

On the whole, prior authorization is a relatively small problem that was expected with the managed care transition. It is slowly improving as payers and providers accommodate to the new status quo. Timely payment, on the other hand, remains a constant issue, and is predicted to continue unless it is addressed.

The alignment of UIHC and the state on the issue of timely payment raises the potential to find a legislative path forward. Legislative proposals such as requiring an MCO to submit an itemized list of information needed in order to process a claim or charge interest on claims not paid timely, are of mutual interest. They are also of interest to patients, and to other providers in the state. Furthermore, there is an existing precedent for prompt payment rules under Chapter 15.32 of the Insurance Division of the Iowa Administrative Code.29 If the state has transitioned to managed care in order to recruit the tools of the private insurance market, it is logical that the state should also import the existing provider protections. Namely:

b. Insurers or entities that administer or process claims on behalf of an insurer who fail to pay a clean claim within 30 days after the insurer’s receipt of a properly completed billing instrument shall pay interest. Interest shall accrue at the rate of 10 percent per annum commencing on the thirty-first day after the insurer’s receipt of all information necessary to establish a clean claim. Interest will be paid to the claimant or provider based upon who is entitled to the benefit payment.

c. Insurers shall have 30 days from the receipt of a claim to request additional information to establish a clean claim. An insurer shall provide a written or electronic notice to the claimant or health care provider if additional information is needed to establish a clean claim. The notice shall include a full explanation of the information necessary to establish a clean claim.

Working with the state to address the issue of prompt payment is also advantageous because it facilitates a relationship that is essential to securing the long-term integrity of the Medicaid system. The problems with prior authorization and timely payment are, in part, symptoms of a problem that begins with oversight, rate-setting, and actuarial calculations by the state. Managed care requires a complete transformation of the role of IME. No longer is the state the direct payer and contractor to providers. Its role is now to procure and audit private managed care organizations.

Incentives must be aligned so that sound actuarial calculations, sound capitation rates, and sound payment rules flow down from IME and through the MCO to the provider. This requires that IME build capacity to better risk-adjust its capitation rates, advance its pay-for-performance metrics and data-collection systems, learn to audit administrative processes, and measure health outcomes. Altogether, actively manage its contracts.7ii Aligning with the interests of IME

7ii “Active contract management,” also known as results-driven contracting, is a method for improving government contracting coined by the Harvard Government Performance Lab. The specific transformations within IME are beyond the scope of this report, but it should be UIHC’s goal to help IME build the capacity to make those changes.
and supporting their ability to “hold MCOs accountable” is essential in order to enforce payment rules because unless it aligns with the MCO’s interest, “we won’t do it until they (IME) say we have to.”

Developing the capacity to actively manage contracts is complicated and expensive. Managed care is unfortunately not as simple as contracting out the role of the state Medicaid agency. If this transition is rushed, or if the state applies pressure to cut costs too quickly, unsound procurement and contract management on the part of the state will cascade downward into excess prior authorizations and delayed payment by the MCOs. For this same reason, working on delayed payment with the state, and helping it build sound contract management capacities, may actually indirectly address unnecessary prior authorizations.

Figure 8. Stakeholders and Roles. Stakeholders are depicted alongside roles for which they are responsible. Sound alignment of incentives in the Medicaid system requires that each stakeholder have the capacity to perform its role. The transition to managed care required a major transformation in the role of the state, which used to occupy the role of the MCO. The state must now build capacity to perform the roles of MCO procurement, data collection, and active contract management. Assisting the state in making that transition may be crucial to relieving the costs of excess prior authorizations and delayed payment.

Finally, building a working relationship with the state is essential to setting the foundation to reform pass-through payments before they phase-out in 2022. UPL payments will have to either be converted into value-based payments or replaced by another form of supplemental payment. Transforming these dollars is a delicate operational and political task, and one that will require close working ties to the state Medicaid agency.

Ultimately, the most important long-term goal for UIHC should be strengthening its relationship with IME in order to help IME develop sound contract management techniques
and restructure supplemental payments. Pursuing prompt payment legislation with the state is one way, in the short-term, to strengthen that relationship.

**Recommendations**

The current political climate, UIHC has an opportunity to build a broad coalition to address its short and long-term priorities. Other providers across the state face the same difficulties with prior authorization and timely payment. And with the ongoing political pressure surrounding Medicaid managed care and the private insurance market, the public’s and their representative’s attention is focused on responding to the failures in the health care system. Even the state administration’s priority is beginning to shift from saving money to ensuring the stability of Medicaid; with an upcoming election in 2018, solving the political fallout of delayed payments, AmeriHealth exit, and denial-of-care lawsuits has begun to supersede the original priority of proving cost reductions.

UIHC should survey this political landscape and use its political capital wisely. UIHC faces severe long-term risks due to changes in pass-through payments under managed care. Ideally, it should build relationships that can carry it through that tumultuous future.

As was discovered investigating the administrative burden of interacting with managed care organizations, the added costs of completing prior authorizations under managed care are significant but small compared to the impending changes to supplemental payments. The added cost of disputing denied claims on the back-end is as large as prior authorizations. The legal precedent for addressing timely payment is much stronger, however, and also aligns UIHC with the interests of the state, which is important in order to secure the long-term integrity of the Medicaid system. UIHC should not sacrifice disproportionate political capital addressing prior authorizations.

**Short-Term Recommendations**

**Address prior authorizations directly with MCOs.**

Prior Authorizations is a relatively small problem, is difficult to legislate, and is gradually improving without intervention. In addition, prior authorizations can be addressed through direct negotiations between UIHC and each MCO, where interests in reducing unnecessary administrative hassle is mutually aligned.

To address prior authorizations with MCOs, UIHC can propose to:

- Share lists of what services require authorization and what criteria must be met for approval.
• Prorate providers’ prior authorizations based on the providers’ approval rate for that authorization. Authorizations for services with a high approval rate can be removed to decrease hassle.

Work with the state to advocate for timely payment rules, including itemized reasons for denial.
Delayed payment and the cost of interacting with managed care organizations to dispute denied claims is as large as prior authorizations but is not improving. It is also considerably easier to legislate as there is a strong legal precedent for timely payment rules based on regulations in the Insurance Division of the Iowa Administrative Code. Furthermore, strengthening prompt payment rules indirectly discourages the use of unnecessary prior authorizations on the front-end because unauthorized medical services inevitably generate lengthy medical necessity disputes on the back-end. Advocating for prompt payment also aligns with the interests of the state, building a relationship that helps build the state’s capacity to oversee managed care organizations.

To address Prompt payment, UIHC can work with the state to:
• Set a time limit by which the MCO must pay a claim or respond with an itemized list of information needed in order to process the denial.
• Charge the MCO interest or a penalty on claims not paid by a given time point.
• Give providers the right to appeal disputes to an independent, third-party
• Develop a regular, independent audit of claims payment.

Build relationships by advocating for efficiency improvements that are of universal interest.
A number of low-cost logistical efficiency-gains are in the mutual interest of all stakeholders. UIHC can work with MCOs and the state to:
• Encourage MCOs to develop electronic websites to submit and adjudicate claims.
• Standardize provider enrollment and credentialing.
• Require with MCOs to load providers by a certain time point.
• Require MCOs and DHS to provide paid claims and encounter data reports to the provider upon request.
• Train providers with Milliman’s Criteria before they engage in peer-to-peer.

Build relationships with patients and the public.
The interests of patients and the public currently align with UIHC on nearly every legislative proposal. UIHC can partner with patient advocacy groups to strengthen the coalition advocating for improving prompt payment and building oversight capacity in IME.

Streamline front-end prior authorization and billing processes
A portion of the administrative hassle of appealing prior authorizations and claims can be relieved if UIHC streamlines its own billing and authorization processes. Training providers in prior authorization rules and appropriate coding will improve claim submission, resulting in “cleaner claims faster.” This recommendation is consistent with the recommendations of recent revenue cycle consultants.
Long-Term Recommendations

Experts expect that many of the prior authorization and prompt payment problems in Iowa’s managed care system will “shake out” over time, with or without UIHC’s leadership. By being a leader in the short-term, however, UIHC can help build relationships to strengthen the long-term integrity of the institution and the Medicaid system. The most important long-term goals for UIHC should be strengthening its relationship with IME in order to help IME develop sound contract management techniques and restructure supplemental payments.

**Help IME build the capacities in needs in order to perform active contract management and fulfill its new role under Medicaid managed care.**
Managed care is not as simple as contracting out the role of the state Medicaid agency. IME must now develop the capacity to perform sound actuarial calculations, set sound capitation rates, audit MCOs, and enforce payment rules. If possible, Iowa would benefit from creating an all-payers claims database that could track spending in the public and private insurance systems. Building these capacities is requires significant financial and human resources. UIHC should advocate for delegating those resources to IME and offer its assistance where appropriate.

**Build a coalition with managed care organizations to advocate for sound actuarial analysis and capitation rates.**
The current problems with prior authorization and delayed payments are likely exacerbated by financial pressure on the MCOs. UIHC can help relieve its own administrative costs by joining with MCOs in advocating for a precise actuary.

**Work with IME to restructure supplemental UPL payments.**
As Iowa’s only tertiary care center, and as one of two public safety-net hospitals in the state, UIHC’s financial integrity is essential to the function of the Medicaid system. The impending phase-out of UPL payments risks stripping a crucial source of funding that compensates for the care that UIHC delivers. UIHC should work with IME and the legislature to find a way to restructure these UPL payments into value-based payments or another type of supplemental funding.
Parting Thoughts

- As value-based payment takes over, the need for prior authorizations will likely decrease. In the current FFS system, prior authorizations are designed to disincentivize unnecessary utilization of medical services. As payers and providers begin to expand shared-risk, bundled and capitated payments, value-based incentives will eventually supplant the role that prior authorizations are filling. In this future, the pressure to coordinate care and control utilization will switch from payer to provider.

- Considering the simultaneous failure of the individual marketplace, there may be a unique opportunity to fix both the individual marketplace and the Medicaid managed care market by offering a Medicaid buy-in. The individual marketplace suffers from low enrollment, poor insurer participation. Medicaid managed care, meanwhile, suffers from high cost per-person costs. Offering a Medicaid buy-in on the exchange would make the exchange more competitive and bring healthier individual purchasers into the Medicaid risk-pool.
Appendices

Appendix A: Iowa’s Medicaid “Modernization”

Iowa boasts a long history of health and welfare programs for low-income families. From indigent care “vouchers” in 1915 to Medicaid “modernization” in 2016, the state has repeatedly striven to provide healthcare to its poorest citizens while adapting its welfare programs in response to changes in the state’s health care delivery system, its budget, and federal health policy. At the same time, Iowa has remained a politically moderate state—looked to as a bellwether for social and political trends. As a “purple” state, Iowa has implemented an array of both progressive and conservative welfare policies, and at times—as it did when it implemented the Affordable Care Act—has carved its own path, down the middle of the road.

Because of its centrist politics, Iowa is often cited (by both political parties) as a successful compromise or a harbinger of what’s to come. The current withdrawal of insurers from Iowa’s health insurance marketplace and Iowa’s privatization of its Medicaid management (referred to, colloquially, as its “Medicaid modernization”) are only the latest of many transformations that have drawn the public eye.

Medicaid Modernization (2016 – Present)

On February 16, 2015, Iowa DHS announced a request for proposals from private insurance companies to manage Iowa’s Medicaid program. As previously mentioned, it was not the first time that Iowa had contracted parts of its Medicaid program to managed care organizations. The state, at that point, had 23 years of experience with PCCM through MediPASS, a history of contracting behavioral health services to Magellan, carving out NEMT, and a two-year history of experimenting with comprehensive care for the remaining health services for a limited portion of its Medicaid population with Meridian. Despite these previous contracts, however, “managed care” in Medicaid was a new idea for most Iowans—one that conjured memories of HMOs and the “Managed Care Revolution” of the 1990s.

The Governor’s proposed privatization was, indeed, on a breadth and scale that had never been attempted in Iowa. In 2013, only 7% of Medicaid members were enrolled in comprehensive managed care. DHS explained that it intended to contract with MCOs to provide comprehensive health care services including physical health, behavioral health and long-term services and supports (LTSS) for nearly all of its Medicaid members. These changes would constitute a dramatic change for Iowa’s Medicaid program. The governor and MCO proponents, however, cited managed care programs in other states as evidence that the change was a modernization and not unprecedented. Indeed, despite the backlash against managed care in the late 90s and 2000s, managed care in Medicaid continued to grow in most states.

DHS announced four winning bidders for the Medicaid Modernization initiative on August 17, 2015. In September, Iowa officially submitted requests to amend its 1115 waiver and enroll all newly eligible adults in MCOs, as well as to begin a Section 1915(b) waiver to expand its
capitated Medicaid managed care system statewide, allowing the state to enroll nearly all existing Medicaid beneficiaries in MCO plans.³¹

The four MCOs selected for the contract were Amerigroup Iowa, Inc., AmeriHealth Caritas Iowa, Inc., UnitedHealthcare Plan of the River Valley, Inc., and WellCare of Iowa. Notably absent from the contract awardees were the two MCOs with which the state currently contracts: Meridian Health Plan and Magellan Health.”³¹

At the time, the Branstad administration projected that privately managed care would save the state more than $51.3 million in its first six months of operation.

**WellCare Dropout.** Former State representative and DHS consultant Ronda Schulte terminated her consulting contract with DHS’s mental health division four days after Governor Branstad declared he was seeking competitive bids from private companies to manage Iowa’s Medicaid program. Four days later she began working for WellCare, one of the four companies originally selected to manage the Medicaid program. WellCare’s contract was terminated in December 18, 2015 following court records and testimony showing company officials—including former state representatives Christopher Rants and Renee Shultee—engaged in prohibited communications, including an effort to uncover the secret identities of committee members reviewing the bids.

**AmeriHealth Dropout.** In the year after managed care go-live, AmeriHealth, like the other managed care organizations, began posting losses of tens of millions of dollars. AmeriHealth subsequently requested a 15 percent capitation rate increase as well as $75 million in reimbursements from the state in order to recover a portion of its losses. The state, however, defended its rates and the reputation of Milliman, the actuarial company that it contracted to set them. With no deal, AmeriHealth announced it would terminate its contract on October 31, 2017.
Appendix B: Current Medicaid Policy Framework

Iowa Medicaid currently has three main coverage groups: IA Health Link, Medicaid FFS, and Hawk-i.

**IA Health Link.** The name “Iowa Health Link” refers to the aggregate of the Iowa Wellness Plan, Marketplace Choice, and Traditional Medicaid FFS populations that are now enrolled in MCOs. Technically, the Iowa Health Link is actually an extension of the 1115 waiver for the Iowa Wellness Plan, which CMS approved on April 1st, 2016.

**Eligibility.**
- **Adult Group.** 0% to 133% FPL.
- **Children.** 0 to 185% FPL.
- **Parents and Other Caretakers.** 0 to 138% FPL.
- **Pregnant Women.** 0 to 185% FPL.

**Verification, Enrollment, & Renewal.** For individuals applying for coverage based on MAGI standards, Iowa uses an alternative single, streamlined Medicaid application that was developed by the state in accordance with section 1413(b)(1)(B) of the ACA, which is “no more burdensome” than the streamlined application developed by HHS. For individuals applying for coverage based on a different, categorically-eligible basis, Iowa uses the application developed by HHS. The state accepts Medicaid applications online, by phone, mail, in-person, and by facsimile. It, however, does not accept online applications for MAGI-based eligibility applications and it does not maintain online accounts where enrollees can manage/upload their information. It automatically renews applications once every 12 months, without requiring information from the individual if the determination can be made using information available to the agency (i.e. tax forms), and if the individual’s coverage cannot be renewed using existing information, Iowa provides a prepopulated renewal application to the individual. Iowa does not automatically renew MAGI-based enrollees. Eligibility and enrollment data is coordinated between Medicaid, CHIP, and the exchanges.32 33

Of note, Iowa reported that its HCBS waiver for persons with intellectual and developmental disabilities (IDD) had reached its federally approved enrollment cap causing the state to implement a waiting list in FY 2015.32

**Premiums and cost sharing policy.** Premiums and cost-sharing are waived for all Iowa Health Link members during their first year of enrollment. After the first year, individuals below 50% of the FPL, medically frail and members in the HIPP population, and all individuals who self-attest to a financial hardship remain exempt from premium payments. Individuals between 51% and 100% of the FPL who are not exempt are charged $5 per month but cannot be disenrolled for nonpayment. Individuals between 101% and 138% FPL who are not exempt are charged $10 per month and can be disenrolled for nonpayment but may reenroll at any time. Whether or not someone is disenrolled, unpaid premiums may be considered a collectible debt owed to the State. Premiums are waived if the beneficiary completes specified Healthy Behaviors, including either an annual wellness exam or an annual health risk assessment. Beneficiaries can also receive a hardship exemption if they cannot pay the premiums.

Iowa charges an $8 copayment for non-emergency use of the emergency room for all
Medicaid beneficiaries. No other cost-sharing charges are levied.

Delivery and Payment Structure

Long-Term Services and Supports (LTSS). Iowa carved LTSS into all of its MCO contracts.

Behavioral Health. Iowa carved inpatient, outpatient, and substance abuse services into its MCO contracts.\textsuperscript{ix}

Patient-Centered Medical Homes (PCMHs).

ACA Health Homes.

Accountable Care Organizations. Iowa, New Mexico and Minnesota expanded ACOs because of new MCO contracting requirements.

Coordinated Care for Dual-Eligible Patients. Iowa is not participating in Financial Alignment Demonstrations (FADs) to coordinate and improve care and control costs for those dually eligible for Medicare and Medicaid.

Episode of Care (Bundled Payments). Iowa Does not have Bundled Payments.

All Payer Claims Database. Iowa Does not have an APCD.

Provider Tax or Fee. Iowa has not increased provider taxes or fees to fund the costs of the ACA Medicaid expansion.

Prescription Cost Control Attempts. None noted.

Medicaid FFS. The vast majority of Medicaid beneficiaries are now enrolled in IA Health Link. Some Medicaid beneficiaries, however, continue to receive coverage through the Medicaid Fee-for-Service (FFS). Medicaid FFS programs include:

Health Insurance Premium Payment Program (HIPP). HIPP helps pay the private insurance premiums for people who receive health insurance through their employer but who also live in a home where someone qualifies for Medicaid.

Medicare Savings Program (MSP). MSP uses Medicaid funds to help pay for premiums, deductibles, and coinsurance for qualifying individuals with Medicare Part A or Part B.

Three Day Emergency. Up to 3 days of Medicaid is available to pay for the cost of emergency services for aliens who do not meet citizenship, alien status, or social security requirements.

Medically Needy. The Medically Needy program helps pay for out-of-pocket expenses for people whose income is too high to qualify for Medicaid but whose medical expenses are so high that they use most or all of their income.

Presumptive Eligibles. Presumptive eligibility (PE) provides Medicaid for a limited time while a formal Medicaid eligibility determination is being made by the Iowa Department of Human Services (DHS).

\textsuperscript{viii} “Two states in FY 2015 (Indiana and Iowa) and four states in FY 2016 (Arizona, Montana, New Hampshire and New Mexico) adopted new copayments for their expansion populations. Four of these states (Arizona, Indiana, Iowa and New Mexico) noted changes in copayments related to non-emergent use of the Emergency Department (ED) for the expansion group; all but one (Indiana) planned to increase such copayments under existing state plan authority (up to $8). Indiana received a waiver under Section 1916(f) to test the effects of higher copayments ($8 for the first use of the ED and then $25 for subsequent use) than otherwise allowed under federal law (Section 1115 waiver authority does not extend to Medicaid cost-sharing requirements).”

\textsuperscript{ix} Arizona, Iowa, Louisiana, New York, Washington and West Virginia carved inpatient, outpatient, and substance abuse services into at least some of their MCO contracts.
**Retroactive Eligibility.** As of November 2017, Iowa Medicaid applicants no longer qualify for 3 months of retroactive Medicaid benefits.

**American Indian or Alaska Native program.** AI/ANs who are eligible for Medicaid may choose to enroll in the IA Health Link managed care program, or may choose to remain in Medicaid FFS.

**Program of All-inclusive Care for the Elderly (PACE).** (PACE) is a specialized managed care program that provides preventive care, primary care, social services, therapeutic recreation, acute and long-term care services for individuals 55 or older, who are living in a community home and meet the need for nursing facility level of care. The goal of the program is to help individuals continue to live at home.

**Hawk-i.** The hawk-i program is now managed by the same MCOs as IA Health Link. It continues to provide coverage for Iowa residents under the age of 19 who have no other health insurance, who are citizens or qualified aliens, and whose families meet income limits. Premiums for hawk-i coverage range from $0-40 per month, depending on the family’s income. Dental coverage is also available for $0-20 per month.
# Appendix C: Administrative Costing Project

The full version of Appendix C is confidential and is formatted as an Excel file. A summary of the data from this file is below.

## Medicaid Managed Care Administrative Costing Comparison

<table>
<thead>
<tr>
<th>Prior Authorizations</th>
<th>Department</th>
<th>Item</th>
<th>Before</th>
<th>After</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-certifications</td>
<td>Utilization Management</td>
<td>Staffing</td>
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<tr>
<td></td>
<td></td>
<td>Activities</td>
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<td>$164,714.32</td>
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<tr>
<td>Pre-authorizations</td>
<td>Patient Billing and Access Services</td>
<td>Staffing</td>
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<td>Psychiatry</td>
<td>Staffing</td>
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<td></td>
<td>Infusion Clinic</td>
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<td></td>
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<td></td>
<td>Neurosurgery</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Otolaryngology</td>
<td>Not Available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pediatrics</td>
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<td></td>
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<tr>
<td></td>
<td>Ophthalmology</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
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**Total:** $1,042,635

## Billing and Appeals (Patient Financial Services)

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<tr>
<th>Activity</th>
<th>Department</th>
<th>Item</th>
<th>Before</th>
<th>After</th>
<th>Change</th>
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<tbody>
<tr>
<td>Billing and Appeals</td>
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<td>Patient Access Management</td>
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<td>Coding Integrity Division</td>
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<td>Revenue Integrity</td>
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**Total:** $1,106,982

**Grand Total:** $2,149,618
Appendix D: Draft Legislation Example, Kansas

Senate Substitute for HOUSE BILL No. 2026

AN ACT amending the Kansas program of medical assistance, process and contract requirements, claims appeal, and first

Revised by the Legislature of the State of Kansas:

Section 1. (a) Upon request by a participating healthcare provider under the Kansas medical assistance program, the secretary of health and environment shall provide accurate and uniform patient encounter data and a monthly summary to the department of health and environment. The information shall be provided in a format that complies with the federal health insurance portability and accountability act of 1996 and applicable federal and state statutory and regulatory requirements, including, but not limited to, the:

1. Managed care organization claim number;
2. Patient identifier number;
3. Patient name;
4. Type of service;
5. Amount billed by revenue code and procedure code;
6. Managed care organization paid amount and paid date; and
7. Hospital patient account number.

(b) Upon receipt of a monthly summary of provider encounter data pursuant to subsection (a), the department of health and environment shall furnish to the participating healthcare provider all requested information within 60 calendar days after receiving the request for data. The department of health and environment may charge a reasonable fee for furnishing requested data, including only the cost of any computer services, excluding staff time required.

(c) (1) The secretary shall require any managed care organization providing state medical or children's health insurance program services under the Kansas medical assistance program to provide documentation to a healthcare provider when the managed care organization denies any portion of any claim for reimbursement submitted by the provider, including a specific explanation of the reason for denial and utilization of a standard appeals process.

(d) Each managed care organization shall offer quarterly in-person training and educational sessions on the utilization and interpretation of reimbursement and payment policies and procedures utilizing a format approved by the secretary and incorporating information collected through semi-annual surveys of participating healthcare providers.

(e) The secretary shall develop uniform standards to be utilized by each managed care organization providing state medical or children's health assistance program services under the Kansas medical assistance program to offer quarterly in-person training regarding billing guidelines, reimbursement requirements and program policies and procedures utilizing a format approved by the secretary and incorporating information collected through semi-annual surveys of participating healthcare providers.

(f) Each managed care organization's subcontracts and managed care organization's subcontractors shall be required to pay the cost of audits conducted under this subsection.

(g) The provisions of this subsection shall expire on January 1, 2020.

(h) The secretary shall require each managed care organization to pay 100% of the state-established per diem rates for nursing facilities for current medical assistance recipients during any re-certification process caused by a change in ownership of the nursing facility.

(i) In the event of a dispute between a participating healthcare provider and managed care organization and after the effective date of this section, a managed care organization providing state medical or children's health insurance program services under the Kansas medical assistance program shall not discriminate against any licensed physician or pharmacist located within the geographic coverage area of the managed care organization that is willing to meet the qualifications and standards established by the Kansas medical assistance program and to accept reasonable contract terms offered by the managed care organization.

(j) The secretary shall adopt rules and regulations as may be necessary to implement the provisions of this section prior to January 1, 2018.

Sec. 2. (a) Any managed care organization providing state medical assistance pursuant to a contract with the Kansas medical assistance program shall include in any letters to a participating healthcare provider reflecting a final decision of the managed care organization's internal appeal process:

(A) A statement that the provider's internal appeal rights within the managed care organization have been exhausted;

(B) A statement that the provider is entitled to an external independent third-party review pursuant to this section; and

(C) The requirements to request an external independent third-party review.

(b) For each instance that a letter does not comply with the requirements of paragraph (1), the managed care organization shall pay to the participating healthcare provider a penalty not to exceed $1,000.

(b) (1) On and after January 1, 2020, a provider who has been denied a healthcare service to a recipient of medical assistance or a claim for reimbursement to the provider for a healthcare service rendered to a recipient of medical assistance who has exhausted the internal written appeals process of a managed care organization providing state medical assistance services pursuant to a contract with the Kansas medical assistance program to a recipient of medical assistance shall be entitled to an external independent third-party review of the managed care organization's final decision.

(2) To request an external independent third-party review of a final decision by a managed care organization, an aggrieved provider shall submit a written request for such review to the managed care organization within 60 calendar days of receiving the managed care organization's final decision resulting from the managed care organization's internal review process. A provider's request for such review shall:

(A) Specify each specific issue and dispute directly related to the adverse final decision issued by the managed care organization;

(B) State the basis upon which the provider believes the managed care organization's decision to be erroneous;

(C) Provide the provider's designated contact information, including name, mailing address, phone number, fax number and email address.

(3) Within five business days of receiving a provider's request for review pursuant to this section, the managed care organization shall...
A. Confirm to the provider’s designated contact, in writing, that the managed care organization has received the request for review;
B. Notify the department of health and environment of the provider’s request for review; and
C. Notify the recipient of medical assistance of the provider’s request for review, if related to the denial of a healthcare service.

If the managed care organization fails to satisfy the requirements of this paragraph, then the provider shall automatically prevail in the review.

4. Within 15 business days of receiving a provider’s request for external independent third-party review, the managed care organization shall:
   A. Submit to the department of health and environment all documentation submitted by the provider in the course of the managed care organization’s internal appeal process; and
   B. Provide the managed care organization’s designated contact information, including name, mailing address, phone number, fax number and email address.

If the managed care organization fails to satisfy the requirements of this paragraph, then the provider shall automatically prevail in the review.

6. A. An external independent third-party review shall automatically extend the deadline to request a hearing before the office of administrative hearings of the department of administration pending the outcome of the external independent third-party review. Upon conclusion of the external independent third-party review, the reviewer shall forward a copy of the decision and a notice of action to the provider, recipient, applicable managed care organization, department of health and environment and Kansas department for aging and disability services. When a deadline to request a hearing before the office of administrative hearings has been extended pending the outcome of an external independent third-party review, all parties shall be granted an additional 30 days from receipt of the review decision and notice of action to request a hearing before the office of administrative hearings.

6. If a recipient of medical assistance or participating healthcare provider files a request for a hearing before the office of administrative hearings regarding a claim for which the provider has filed a request for external independent third-party review, the department of health and environment and the Kansas department for aging and disability services shall immediately request a continuance from the office of administrative hearings. The department of health and environment and the Kansas department for aging and disability services shall forward the decision of the review to the office of administrative hearings for consideration by the hearing officer together with any other facts of the case.

7. Upon receiving notification of a request for external independent third-party review, the department of health and environment shall:
   A. Assign the review to an external independent third-party reviewer;
   B. Notify the managed care organization of the identity of the external independent third-party reviewer; and
   C. Notify the provider’s designated contact of the identity of the external independent third-party reviewer.

8. The department shall deny a request for external independent third-party review if the requesting provider fails to:
   A. Exhaust the managed care organization’s internal appeal process;
   B. Submit a timely request for an external independent third-party review pursuant to this section.

9. Multiple appeals to the external independent third-party review process regarding the same recipient of medical assistance, a common question of fact or interpretation of common applicable regulations or reimbursement requirements may be determined in one action upon request of a party in accordance with rules and regulations adopted by the department of health and environment. The provider that initiates a request for an external independent third-party review process, or one or more other providers, may add other initial denials of claims to such review prior to final decision and after exhaustion of any applicable written internal appeals process of the applicable managed care organization if the claims involve a common question of fact or interpretation of common applicable regulations or reimbursement requirements.
Appendix E: Legislative Priorities Grid (Confidential)

This appendix is an annotated version of the “Legislative Priorities Grid” on page 39, explaining rationales for the scoring and ranking of the various policy proposals.
## Appendix F. Legislative Changes to Improve Managed Care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Rationale &amp; Draft Language (if available)</th>
</tr>
</thead>
</table>
| **Timely payment and correction of claims processing errors** | Timely payment guidelines exist in provider-MCO contracts, however there is currently no standard by when MCOs must process, pay, or respond to a claim, and there are insufficient penalties for failing to comply. What guidelines exist are written into contracts and vary by MCO. In addition, when an MCO denies a claim, the MCO’s response is often unclear or nonspecific (e.g. “Denied per policy”). **It is important the MCO responses be itemized and contain specific instructions** about why a claim was denied and what information is needed in order to process it.  
- “When all of the listed documents or other information needed to process the claim have been received by the insurer or administrator, the insurer or administrator shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the facility or health care provider claiming payments under the plan the insurer's or administrator's reasons for such denial.” (Georgia §33-24-59.14)  
- “...the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan... The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.” (California HSC § 1371)  
- “The secretary shall require any managed care organization...provide documentation to a healthcare provider when the managed care organization denies any portion of any claim for reimbursement submitted by the provider, including a specific explanation of the reasons for denial and utilization of remark codes, remittance advice and health insurance portability and accountability act of 1996 standard denial reasons.” (Kansas HB2026)  
If possible, it would also be ideal if MCO responses used the same language.  
- The secretary shall standardize the coding and format of responses across MCOs. |
| **Set a time limit by which the MCO must pay a claim or respond with an itemized list of the information needed to process the claim.** |  |
| **Set a time limit by which the MCO must resolve appeals.** | MCO claims processing systems have programming errors that cause systemic over and underpayment of provider claims. If a provider identifies a claims programming or provider data load error that causes incorrect denials or inaccurate payment resulting in either over or underpayment, there shall be timely correction of such errors.

- After notification by a provider or discovery of such an error in claims or authorization payment/approval processes, MCOs shall have 30 days to correct such programming or process, and 60 days to fully and accurately reprocess the claims affected by the error.
- “Each managed care organization, within 60 calendar days of receiving an appeal request, provide notice and resolve 100% of provider appeals, subject to remedies, including, but not limited to, **liquidated damages** if provider appeals are not resolved within the required time.” (Kansas HB2026) |
| **Charge the MCO interest or a penalty on claims not processed by the time limit.** | Without legislating an interest rate on claims, the interest rate defaults to 0%.

- “Each insurer or administrator shall pay to the facility or health care provider claiming payments under the health benefit plan interest equal to 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply.” (Georgia §33-24-59.14)
- “An insurer that fails to pay, deny, or settle a clean claim in accordance with the time periods set forth... shall pay interest at the rate of twelve percent per annum on the total amount ultimately allowed on the claim...” (Nebraska 44-8005)
- “If an uncontested claim is not reimbursed by delivery to the claimants’ address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum.” (California HSC § 1371)
- “An insurer or administrator may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer or administrator processes less than 95 percent of all claims in a standard financial quarter in compliance” (Georgia §33-24-59.14) |
| **Charge the MCO interest or a penalty on claims incorrectly denied or underpaid.** | Claims found to be incorrectly denied or underpaid (through the appeals process or audit) should also be subject to interest or a penalty. This will create an incentive for timely correction of incorrect payments and denials. In Iowa, providers are still dealing with incorrect payments and denials that are 9-18 months old.  
- “For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted.” (Georgia § 33-21A-7) |
| **Require the MCO to pay any undisputed portion of a claim.** | This language already exists in contracts, but would be prudent to have coded in law.  
- “Where the insurer or administrator disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer or administrator in accordance with this chapter.” (Georgia §33-24-59.14)  
- “If a qualified health plan determines that 1 or more covered services listed on a claim are payable, the qualified health plan shall pay for those services and shall not deny the entire claim because 1 or more other covered services listed on the claim are defective or because 1 or more other services listed on the claim are not covered services.” (Michigan 400-111) |
| **Supplemental Payments and Rate Changes** | MCOs make State University of Iowa Physician Supplemental payments in capitated payments that are required to be no later than the 15th day of the month. There is no penalty or interest charged, however, if the payment is late. |

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**Note:** The above table provides a summary of the current and potential legal requirements for MCOs regarding claims, interest, and rate changes. The specific language and requirements vary by state and the details provided are based on the information available at the time of writing. Always consult the latest legal documents and regulations for the most accurate and up-to-date information.
Set a time limit on retroactive rate decreases by IME

Any proper resolution achieved through the aforementioned statutes is jeopardized by retroactive rate changes by IME. Examples include rebase delays, Addendum B update delays, cost containment or other payment changes and delays on the PMPM rates.

- Retroactive rate decreases shall not extend further than 3 months from the time of final rate decisions.

Appeals and External Review

Give providers the right to appeal disputes to an independent, third-party for external review and Standardize the appeals process for disputed claims

Consistent with the commercial insurance market, Providers should have the right to appeal an MCO decision and request an external review by an independent third party:

- “On and after January 1, 2020, a provider who has been denied a healthcare service to a recipient of medical assistance or a claim for reimbursement to the provider for a healthcare service rendered to a recipient of medical assistance and who has exhausted the internal written appeals process of a managed care organization providing state Medicaid services pursuant to a contract with the Kansas program of medical assistance shall be entitled to an external independent third-party review of the managed care organization’s final decision.” Details in bill. (Kansas HB2026)

- “The commissioner shall establish an external review procedure…” Details in bill. (Michigan 400-111)

- “The secretary shall develop…a grievance, appeal and state fair hearing process that complies with applicable federal and state statutory and regulatory procedure requirements, including any statutory remedies for timely resolution of grievances, appeals and state fair hearings” (Kansas HB2026)

The right to an independent, third-party, external review should be integrated into a standardized appeals process, consistent with state and federal fair hearing processes:

**Recommended Appeal Step 1: Internal Review with MCO**

- First appeal occurs with the MCO. Providers may request appeal of MCOs decisions. Action within 15 days.

- MCO establishes appeal process with independent judge. Provider produces Medicaid payment policy supporting provider claim is covered under Medicaid policy to MCO. Hearing within 15 business days, decision within 15 business days. MCO must rule consistent with Medicaid rule, SPA, and written policy.

- If policy is unclear, DHS must provide guidance within 15 days to the MCO and the provider to
### Appeal Step 2 – External Review

- Consistent with the commercial insurance market, Providers may request external review by an independent third party to appeal MCO decision, similar to External review process of the Iowa Insurance Division. Independent Review organization has up to 45 days to issue a decision for the external review.
- External Review Organization is contracted by DHS, and is an independent body from either DHS or the MCOs. Similar to the structure used by IID.

### Appeal Step 3 – District Court

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<th>Allow provider to bundle claims during the appeals process.</th>
<th>This practice is permitted under current contracts and norms, but would be prudent to have coded in law.</th>
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<tr>
<td></td>
<td>“a care management organization shall allow providers to consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims” (Georgia § 33-21A-7)</td>
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<tr>
<td>Set a maximum time limit after which claims default to appeal or binding arbitration</td>
<td>Because many claims remain in dispute between the payer and provider, regarding whether or not they compose a “clean claim,” it is logical to set a maximum time limit by which a claim must be processed or rescinded, after which the claim automatically defaults to a predefined appeals process or binding arbitration.</td>
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<td>If a claim is in dispute for longer than 6 months from the time it is submitted, that claim will advance to external review per the predefined appeals process.</td>
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<td>Create a regular, independent audit of claims payment, paid for by the MCOs.</td>
<td>“The secretary shall procure the services of an independent auditor for the purpose of reviewing, at least once per calendar year, a random sample of all claims paid and denied...Each managed care organization and each managed care organization’s subcontractors shall be required to pay any claim that the independent auditor determines to be incorrectly denied. Each managed care organization and each managed care organization’s subcontractors may also be required to pay liquidated damages... Each managed care organization and each managed care organization’s subcontractors shall be required to pay the cost of audits conducted under this subsection.” (Kansas HB2026)</td>
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<td>Require DHS to investigate and penalize insurers for patterns of inaccurate</td>
<td>Require DHS to investigate and penalize insurers for patterns of “unfair payment.” The investigation would be paid for by the insurer.</td>
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<td><strong>Logistics and Documentation</strong></td>
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<td><strong>Require MCOs to maintain an electronic website to submit and adjudicate claims.</strong></td>
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<td>All MCOs currently maintain a website where providers can submit and view claims, however some MCOs do not allow providers to submit “claim disputes”, “reconsiderations”, and “appeals” on their website. This process is standard among other commercial payers. This lack of functionality means that providers must contest claims over the phone and maintain a separate log of a claim’s status, rather than participating in an open and shared record.</td>
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<tr>
<td>• “Each care management organization shall maintain a website that allows providers to submit, process, edit, rebill, and adjudicate claims electronically.” (Georgia § 33-21A-7)</td>
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<td>• The website must allow providers to request reconsiderations and submit provider inquiries and claim disputes.</td>
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<tr>
<td><strong>Standardize Provider Enrollment and Credentialing.</strong></td>
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<td>• “The secretary shall develop… A standardized enrollment form and a uniform process for credentialing and re-credentialing healthcare providers who have signed contracts or participation agreements with any such managed care organization” (Kansas HB2026)</td>
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</table>
**Require MCOs and DHS to provide paid claims and encounter data reports to the provider upon request.**

MCOs already submit paid claims report data regularly to the state, however those reports are not shared with providers. This data is needed by providers to produce required Medicaid Cost Reports submitted to the state. The providers’ paid claims data needs to be shared timely in order to verify accuracy and allow for budgeting and forecasting.

- **MCOs must provide a customized paid claims (encounter) data report to the provider within 60 days upon request.**
- **“Upon request by a participating healthcare provider under the Kansas medical assistance program, the secretary of health and environment shall provide accurate and uniform patient encounter data that complies with the federal health insurance portability and accountability act of 1996 and applicable federal and state statutory and regulatory requirements, including, but not limited to, the:**
  - Managed care organization claim number;
  - Patient Medicaid identification number;
  - Patient name;
  - Type of claim;
  - Amount billed by revenue code and procedure code;
  - Managed care organization paid amount and paid date; and
  - Hospital patient account number

  **Upon receiving a request for patient encounter data pursuant to subsection (a), the department of health and environment shall furnish to the participating healthcare provider all requested information within 60 calendar days after receiving the request for data. The department of health and environment may charge a reasonable fee for furnishing requested data, including only the cost of any computer services, including staff times required.” (Kansas HB2026)**

**Prior Authorizations**

**Eliminate unnecessary prior authorization for ICU admissions.**

The purpose of MCO authorization of inpatient admissions is to ensure that all admissions are medically necessary. The amount of documentation and review is currently burdensome. Certain levels of care within hospitals are obviously medically necessary and authorization is unnecessary, such as admissions to Intensive Care Unit level of care. ICUs require evaluation by two clinical teams for admission (the admitting team and the ICU team before admission because it is a limited resource. This creates an inherent check and balance against inappropriate admission. ICUs have much higher cost to operate and staff and are always a limited availability in a hospital. The current DRG system, which pays a fixed per diem based
| Allow more time for providers to complete prior authorizations for inpatient admissions (2 business days). | Providers are only given 24 hours from the time of admission to request MCO authorization of the inpatient admission. MCOs have to issue approval or denial within very time timelines per the contracts or face financial penalties. Often the clinical information and documentation is not available in 24 hours to provide to the MCOs, and given the MCO contracts, they are forced to issue denial. The next step after Denial is ‘peer to peer’ review, which requires the provider physician and the MCO physicians to speak on the phone, which is a very time consuming process for physicians. This process could be improved by adding more time for the provider to provide information and by offering a second step option before requiring peer to peer (and reduce the eventual number of peer to peer consultations).

- Providers shall have 2 business days to provide information for authorizations of inpatient admissions.
- If authorization is denied, providers may request reconsideration to provide further information within 2 business days.
- If denied, then peer to peer step is initiated.
- This will require amendments to the MCO contracts to provide more time for these steps |

| Create a fee for completing a prior authorization | Prior authorizations represent a significant tax on provider staff and resources. To address this, the Provider should be permitted to charge the MCO a fee in order to recover the lost productivity due to interacting with the MCO.

- The MCO will be charged a fee for every prior authorization, proportionate to the lost productivity of the provider due to completing the prior authorization process. |

| Standardize the deadlines for filing clinical documentation, submitting appeals, and completing peer-to-peer. | MCOs vary in the times they prescribe.

- All MCOs will allow at least 7 days for the provider to complete pre-certification for unscheduled admission. |
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<th>Require MCOs to aggregate Pre-certifications and Pre-authorization denials in one communication a day</th>
<th>Utilization management currently receives five emails a day from some MCOs—each with its own deadline 24 hours from the time of receipt. This creates confusion and unnecessary logistical burden for utilization management.</th>
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<tr>
<td>Allow providers to request a reconsideration of prior authorization denial before having to submit written appeal or complete a peer-to-peer.</td>
<td>Under the current system, providers shoulder the initial burden of proof when an authorization is denied. When an authorization is denied, the provider must decide whether to pursue an appeal, often requiring a lengthy literature review or peer-to-peer process. By creating an interim step whereby, the provider can request that the MCO reconsider its denial, there is an opportunity to avoid a lengthy appeal process for both the provider and the MCO.</td>
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<td>Align FDA approved medications with the IME and MCO formularies.</td>
<td>Standardizing the formularies and indications for therapy between the state and the MCOs would help eliminate confusion over what was covered and when.</td>
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<td>Carve out high-cost medications from the state’s managed care contracts and create a cost pool for covering those medications.</td>
<td>If the state reclaimed responsibility for administering high-cost medications, providers could avoid the laborious process of appealing these authorizations with MCOs. Instead, providers would go directly to the state for authorization and payment of high-cost medications, such as Spinraza and Sovaldi.</td>
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Appendix G: Actions to Date (Confidential)

This appendix is a chronology that summarizes actions that UIHC and its affiliates have taken to address the costs of prior authorization and payment delays.
Bibliography


15. Sparer MS. Medicaid Managed Care Reexamined. Medicaid Institute at United Hospital Fund; 2008.


