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NEWS RELEASE

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FOR RELEASE July 13, 2020

Auditor of State Rob Sand today released a report on managed care contracts established by the Iowa Medicaid Enterprise, a division of the Department of Human Services (DHS), for the period April 1, 2016 through July 31, 2019. The review was conducted in conjunction with the audit of the financial statements of the State of Iowa and in accordance with Chapter 11 of the *Code of Iowa*. The contracts were reviewed to identify provisions for services for Medicaid members/enrollees in Iowa who participate in the IA Health Link program and to compare certain provisions in the contracts to contracts established by states which are similar to Iowa.

Sand reported the contracts established by Iowa include certain criteria that were not typically included in the other states' contracts or agreements, such as a prohibition regarding arbitrary reduction of managed care organizations (MCOs) staff who serve members that require individualized care without a clinical reason. In addition, for the states selected for review, only Iowa included contract provisions which require the MCOs to maintain data for incurred but not yet reimbursed claims.

Sand also reported Iowa MCO contracts do not require a standardized health information system to be used by the MCOs. To improve accuracy and efficiency, Sand recommended DHS require MCOs to use similar coding mechanisms for claims. A standardized coding system would help achieve efficiencies by providers preparing claims, by the MCO processing claims, and by DHS during oversight procedures.

A copy of the report is available for review on the Auditor of State's web site at http://auditor.iowa.gov/reports/audit-reports/.

# # #

A REVIEW OF MANAGED CARE ORGANIZATION CONTRACTS ESTABLISHED BY THE IOWA MEDICAID ENTERPRISE WITHIN THE DEPARTMENT OF HUMAN SERVICES

FOR THE PERIOD
APRIL 1, 2016 THROUGH JULY 31, 2019

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Auditor of State's Report

To the Governor, Members of the General Assembly,
the Director of the Department of Human Services
and the Director of the Iowa Medicaid Enterprise:

In conjunction with our audit of the financial statements of the State of Iowa and in accordance with Chapter 11 of the *Code of Iowa*, we have reviewed the contracts established between the Department of Human Services (DHS) and Managed Care Organizations (MCOs) to identify provisions for services for Medicaid members/enrollees in Iowa who participate in the IA Health Link program and compare certain provisions in the MCO contracts to MCO contracts established by states which are similar to Iowa. The review covered the period April 1, 2016 through July 31, 2019. In conducting our review, we performed the following procedures:

(1) Determined if the contracts contained specific provisions related to:

- Educating Medicaid members and providers on Early and Periodic Screening, Diagnosis and Treatment services (EPSDT).
- Staffing and case management for Medicaid members with intellectual and/or developmental disabilities, or specialized/individualized care needs.
- Coverage for Medicaid members regardless of diagnosis, illness, or health condition.
- Distance or time requirements in which both urban and rural Medicaid members were to be able to access primary care, specialty care, and hospital providers.
- The Medicaid member grievance and appeal process and the timeframes required by the MCOs to resolve these actions.
- Exception to policy for Medicaid members to request services outside the plan coverage.

(2) Determined if the contracts include provisions which require the MCOs to provide DHS complete and accurate claims data (clean claims) in order to receive full payment for services.

(3) Determined if contract provisions established data reporting requirements for provider claims submitted to the MCOs but not yet paid.

(4) Determined if contracts required the MCOs to ensure encounter data was accurate and reported to DHS. We also determined if DHS performed review and/or monitoring of encounter data.

(5) Determined if contracts include provisions related to pharmacy services, proper billing procedures, and administration of pharmacy benefits by the MCOs.

(6) Determined if contracts contained requirements regarding payment of state income taxes and jobs in the state in which the MCOs conduct business, such as requiring in-state employees to operate call centers and/or hotlines and complying with minority and women owned business laws for any subcontractors.

(7) Determined if contract included performance measures which were tied to the MCO Healthcare Effectiveness Data and Information Set (HEDIS) score. We also determined if there were any incentives associated with that score.

Based on these procedures, we determined the MCO contracts established by Iowa do not significantly vary from the contracts/agreements established by other states selected for review. However, the contracts established by Iowa include certain criteria that were not typically included in the other selected states' contracts/agreements, such as a prohibition regarding arbitrary reduction of MCO staff who serve members that require individualized care without a clinical reason. In addition, for the states selected for review, only Iowa included contract provisions which require the MCOs to maintain data for incurred but not yet reimbursed claims. Our detailed findings are presented in this report.

The procedures described above do not constitute an audit of financial statements conducted in accordance with U.S. generally accepted auditing standards. Had we performed additional procedures other matters might have come to our attention that would have be reported to you.

Rob Sand
Auditor of State

June 19, 2020

Introduction

Medicaid Background

The Department of Human Services (DHS) is authorized by section 217.1 of the *Code of Iowa* to administer programs designed to improve the well-being and productivity of the people of the State of Iowa. In accordance with the *Code*, the programs administered by DHS must focus on the problems of human behavior, adjustment, and daily living through the administration of programs of family, child, and adult welfare, economic assistance including costs of medical care, rehabilitation toward self-care and support, delinquency prevention and control, treatment and rehabilitation of juvenile offenders, care and treatment of persons with mental illness or an intellectual disability, and other related programs as provided by law.

Title XIX of the Social Security Act is the legal basis for Medicaid. Medicaid is a state administered program which provides medical assistance to financially needy adults, children, parents with children, people with disabilities, elderly people and pregnant women who meet certain eligibility criteria. As part of the Social Security Act, each state establishes its own guidelines regarding eligibility and services.

At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services. In order to participate in Medicaid, the state legislature must appropriate funds and designate a state agency to administer the program.

The Medicaid program in Iowa is managed by DHS. Medicaid pays for health care services for individuals with limited income and resources who meet Medicaid eligibility requirements. Section 249A.3 of the *Code of Iowa* states mandatory medical assistance shall be provided to individuals residing in the State of Iowa who meet eligibility requirements. Medicaid is funded by both the state and federal government and costs are shared.

Prior to 2016, providers who want to serve Medicaid eligible individuals applied to DHS through Medicaid's provider enrollment process. Providers who were determined to be licensed and in good standing were allowed to become an authorized Medicaid provider. After providing services to Medicaid members, authorized providers billed DHS for the services and were paid on a fee-for-service basis.

DHS released a Request for Proposal (RFP) for Medicaid Modernization (managed care) on February 16, 2015. The RFP requested bids from potential vendors as the State moved toward a risk-based managed care approach for Iowa's Medicaid program. On August 17, 2015, DHS issued a notice of intent to award contracts to four Managed Care Organizations (MCOs) to administer the program. Specifically, the notice of intent identified the Amerigroup Iowa, AmeriHealth Caritas Iowa, United Healthcare Plan of the River Valley, and WellCare of Iowa. On December 18, 2015, the selection of WellCare of Iowa was terminated.

DHS intended to make the switch to managed care on January 1, 2016; however, CMS determined additional time was needed to make the transition. Based on available documentation, CMS indicated the State failed to meet certain implementation goals, such as MCO provider networks were not fully developed and lacked key providers. As a result, DHS transitioned most Iowa Medicaid members from a fee-for-service based program to a Medicaid managed care system called IA Health Link on April 1, 2016.

AmeriHealth Caritas Iowa exited the managed care program in November 2017 which left two MCOs providing services. United Healthcare Plan of River Valley exited the managed care program in June 2019; however, DHS established a contract with the MCO Iowa Total Care – Centene which was effective July 1, 2019. As a result, services have been provided by two MCOs since November 2017.

As previously stated, prior to implementation of managed care, Medicaid services were primarily paid using a fee-for-service method. Under the fee-for-service method, health care providers were paid for each allowable covered service provided to a Medicaid beneficiary. Payments were made by DHS, Iowa Medicaid Enterprise (IME), after receipt of a claim from a provider. Under managed care, IME pays a monthly capitation payment to the MCO for each member enrolled in the plan. The MCO then pays providers for the allowable services provided to Medicaid beneficiaries. A capitation payment, similar to an insurance premium, is the payment made each month by the State to the MCO on behalf of each beneficiary enrolled in the plan, based on the actuarially determined capitation rate for the provision of services under the State plan.

Each MCO is licensed as a Health Maintenance Organization (HMO) through the State of Iowa and is required to comply with all rules applicable to HMOs. Under the MCO structure, DHS still retains control over Medicaid member eligibility determinations, sets policy, and determines level of care (LOC) for each individual deemed eligible under Medicaid. In addition, DHS still enrolls Medicaid providers; however, the providers must also enroll with the MCOs.

Eligibility determination is done by staff in the Department of Human Services' local offices, by the Centralized Facility Eligibility Unit, or, for certain groups, by staff of the Social Security Administration or by qualified providers. The Department has local offices throughout Iowa. Income maintenance workers are responsible for maintaining the Medicaid eligibility records for all members. Each member's eligibility information is entered into a centralized automated system.

To be eligible for Medicaid an individual must:

- Live in Iowa.
- Be a U.S. citizen or an alien who is in this country legally.
- Provide a Social Security number or proof that they have applied for one.
- Provide other information (such as financial and size of family).

Eligibility for Medicaid is based primarily on an individual's financial situation. The federal government requires states to provide coverage for:

- A child under the age of 21.
- A parent living with a child under the age of 18.
- A woman who is pregnant.
- A person who is elderly (age 65 or older).
- A person who is disabled according to Social Security standards.
- A woman in need of treatment for breast or cervical cancer.
- In addition, others may qualify:
    - Adults aged 19 to 64 with income up to and including 133 percent of the Federal Poverty Level.
    - If the individual's income is too high for Medicaid but their medical costs are so high that it uses up most of their income, they may qualify for some payment help through the Medically Needy plan.
    - If the individual's income is low and they have a hard time paying Medicare premiums, Medicaid may be able to help pay the premiums.

- If individuals are between the ages of 12 to 54, Iowa's family planning program may be able to help with the cost of family planning related services.
- Individuals 65 or older, blind, or disabled and have a special financial need not met by Social Security, may be eligible for an additional benefit through State Supplementary Assistance.

In addition to determining eligibility, DHS is responsible for ensuring the data submitted by the MCOs regarding services provided are accurate and complete. This is referred to as encounter data and includes information such as the patient served, the date of service, the type of service provided, the duration or quantity of services, and identification of the provider. According to DHS representatives, a staff member reviews encounter data submitted by the MCOs and if any errors are identified, the encounter data submitted is rejected and sent back to the MCOs. This review process continues until the entire submission is complete and accurate. This process is commonly called the "MCO churn" by DHS representatives. After the encounter data submitted by the MCOs has been reviewed and determined to be free of errors, the encounter data is accepted by DHS and remitted to CMS.

Medicaid Managed Care Organizations (MCOs)

As part of the State of Iowa's Medicaid modernization initiative, DHS announced in August 2015 its intent to award four contracts to MCOs as the state moved toward a risk-based managed care approach for Iowa's Medicaid program. According to media reports, DHS representatives stated the initiative was designed to improve the quality and access of the Medicaid program, promote accountability for outcomes, and create a more predictable and sustainable Medicaid budget. The four MCOs DHS announced to receive the initial contracts were:

- Amerigroup Iowa, Inc.,
- AmeriHealth Caritas Iowa, Inc.,
- UnitedHealthcare Plan of the River Valley, Inc., and
- WellCare of Iowa, Inc.

The selection of WellCare of Iowa, Inc. was terminated in December 2015. The remaining three contractors initiated MCO health plans under Iowa Medicaid beginning April 1, 2016, when Iowa transitioned most Medicaid members to the DHS managed care program called "IA Health Link".

As previously stated, since the initiation of managed care for Iowa Medicaid on April 1, 2016, the following changes have occurred regarding the MCOs providing services:

- AmeriHealth Caritas, Inc., withdrew effective November 30, 2017.
- UnitedHealthcare Plan of the River Valley, Inc., withdrew effective June 30, 2019.
- Iowa Total Care began providing services effective July 1, 2019.

As a result of these changes, Iowa has had two MCO contractors providing services to Iowa's Medicaid beneficiaries enrolled in the IA Health Link program since July 1, 2019, including Amerigroup Iowa, Inc. and Iowa Total Care.

DHS established contracts with the MCOs prior to the MCOs providing services under the new Medicaid initiative. Copies of MCO contracts obtained from DHS include approximately 15 sections with each section identifying certain requirements. **Table 1** lists the 15 sections identified in the contracts.

Table 1

Section Number	Title
1	Purpose and Background
2	General and Administrative Requirements
3	Scope and Covered Benefits
4	Long Term Service and Support
5	Billing and Collections
6	Provider Network Requirements
7	Enrollment
8	Member Services
9	Care Coordination
10	Quality Management and Improvement Strategies
11	Utilization Management
12	Program Integrity
13	Information Technology
14	Performance Targets and Reporting Requirements
15	Termination

Each section identified in the **Table** includes several subsections which identify requirements in detail, such as taxes, pharmacy benefits, and grievance and appeals processes.

The Iowa Medicaid program has three primary coverage groups:

- **IA Health Link**. Most Iowa Medicaid members are enrolled in IA Health Link which is a program administered by contracted MCOs. The MCOs provide members with comprehensive medical, behavioral, and long-term care services and support. The MCOs have a comprehensive network of healthcare providers to provide care to all members. Programs and plans under IA Health Link include the Iowa Health and Wellness Plan, Long Term Care program, Home and Community Based Services (HCBS) Waivers program, Medicaid for Employed People with Disabilities, Medicare Assistance for Dual Eligibility, and Family Planning Program.
- **Children's Health Insurance Program (CHIP), also known as Healthy and Well Kids in Iowa program, or HAWKI**. Members receive services through an MCO which provides healthcare coverage for children and families whose family income is too high to qualify for Medicaid, but too low to afford individual or work-provided healthcare coverage.
- **Medicaid Fee-for-Service**. As previously stated, prior to implementation of managed care, Medicaid services were primarily paid using a fee-for-service method. Under the fee-for-service method, health care providers were paid for each allowable covered service provided to a Medicaid beneficiary. Payments were made by DHS, Iowa Medicaid Enterprise (IME) after receipt of a claim from a provider. Under managed care, IME pays a monthly capitation payment to the MCOs for each member enrolled in the plan and the MCOs pay providers for the allowable services provided to Medicaid beneficiaries. The capitation payments, similar to insurance premiums, are based on an actuarially determined rate for the provision of services under the State plan.

  Some Medicaid members continue to receive services under the Fee-for-Service model including members participating in the HIPP (Health Insurance Premium Payment) program, Medicare Savings Program, Three Day Emergency program, Medically Needy program (also known as the Spenddown Program), Presumptive Eligibility program, Retroactive Eligibility program, Program of All-Inclusive Care for the Elderly (PACE) program, and American Indian or Alaskan Native program.

Objectives, Scope, and Methodology

Objectives

Our review was conducted to determine:

- How Iowa's MCO contracts compare to similar states' MCO contracts relative to key contract provisions.
- If there were provisions in other states, whether their differences from Iowa's might be beneficial to incorporate into Iowa's MCO contracts.

Scope and Methodology

To gain an understanding of the provisions in the MCO contracts established for the Iowa Medicaid program, we:

- Obtained and reviewed all MCO contracts effective during the period April 1, 2016, through July 31, 2019.
- Obtained and reviewed demographic information for other states, including demographics relevant to the Medicaid program administered by each state reviewed, to identify states with characteristics similar to Iowa's demographics and determine which states to which to perform a comparison of MCO contract provisions.
- Obtained and reviewed MCO contracts established by the following states: Colorado, Hawaii, Kansas, Kentucky, Maryland, Minnesota, Nebraska, New Mexico, Ohio, Oregon, Rhode Island, Tennessee, and Washington.
- Compared certain MCO contract provisions between Iowa and the other states selected to determine if Iowa's contract language was similar to other states with similar demographics.

Contract Comparisons

As previously stated, DHS was responsible for creating contracts with the MCOs prior to providing services under the new Medicaid initiative. As part of creating a contract, DHS was responsible for determining what provision to include in the contracts with the MCOs. In addition, DHS was responsible for determining if each contract would be specific to the MCO or if the contracts would be standard to allow the same language used for all MCO contracts.

Based on our review of the MCO contracts DHS established, a standard contract was used for all of the MCOs which contracted with DHS. For some states, individual MCO contracts were not available; therefore, model contracts/agreements were reviewed. The MCO contracts or model contracts we reviewed for Iowa and the other selected states are listed **Schedule 1**.

Selected Contract Provisions Reviewed

As previously stated, we compared certain MCO contract provisions between Iowa and other selected states to determine if Iowa's contract language was similar to other states with similar demographics. The MCO contracts included requirements related to, but were not limited to, coverage of services for Medicaid members, the administrative practices in place by the MCOs to carry out its Medicaid plan coverage, and the provisions in place under the MCO contracts to address member grievances and appeals. Each of these categorical requirements also included specific provisions. Selected contract provisions are discussed in further detail in the following paragraphs.

Early and Periodic Screening, Diagnosis and Treatment Services

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally required Medicaid benefit for individuals under the age of 21 years which expands coverage for children and adolescents beyond adult limits to ensure availability of (1) screening and diagnostic services to determine

physical and mental deficiencies and (2) healthcare, treatment, and other measures to address any deficiencies or chronic conditions discovered.

Iowa's EPSDT program is referred to as "Care for Kids". Under the EPSDT services, Iowa's MCOs are required to implement strategies to ensure Medicaid members complete health screens and preventative visits. Screening exams consist of a health history, developmental history, complete physical exam, vision screening, hearing test, appropriate laboratory tests, immunizations, nutrition screen, health education including anticipatory guidance, oral health assessment, and any other tests as needed and referrals for treatment. Iowa's MCO contracts require the MCOs to develop outreach procedures in order to provide education to members and healthcare providers regarding EPSDT services.

All of the contracts/agreements we reviewed included the requirement to provide education to providers and members regarding EPSDT. We did not identify any language in any contracts reviewed which included additional requirements.

Community-Based Case Management

Community-based services are support services necessary for Medicaid members with intellectual, developmental, or physical disabilities to live healthy and safe lives at home and to be a part of their community. These individualized services are delivered via a person-centered plan in a community and the setting of the member's choice.

A member who qualifies for community-based services is assigned a case manager who works with the individual's family to coordinate medical, social, educational, housing needs, transportation, vocational, and other necessary services and support into an integrated plan of care. Responsibilities of a case manager include:

- Assistance with navigating the service system and gaining access to services;
- Coordination of services using multiple service providers/agencies and establishing crisis plans to meet the health and safety needs of the consumers served;
- Securing/managing funding for services;
- Working with the individual, their parent(s)/guardian, and other members of the service team to develop an individualized integrated care plan;
- Coordination and monitoring of ongoing services and monitoring progress towards goals in the care plan as well as the health and safety of each consumer served; and
- Monitoring the individual to assess the health, safety, and wellbeing of the individual.

Some Medicaid members receive case management services, or targeted case management, through the Medicaid Fee-for-Service program (FFS). Under FFS, Medicaid members within populations which qualify for certain Medicaid waiver programs are assigned a case manager in one of the fifteen DHS offices statewide who can work with the member, their family, service providers, and other agencies to integrate services from multiple providers and funding streams.

According to Iowa's MCO contracts, MCOs are required to provide for the delivery of community-based case management services as part of their Medicaid managed care contracts for Medicaid members that are not eligible for a waiver program. These services are the equivalent of targeted case management services and are provided to Medicaid members receiving long term services and supports (LTSS) through such providers as nursing facilities, intermediate care facilities for individuals with intellectual disabilities, state resource centers, and services funded through home and community-based services waivers.

In addition, Iowa's MCO contracts state MCOs are required to assign to each Medicaid member receiving community-based services a case manager who is the member's main point of contract with the MCO and the service delivery system. The contracts also state the MCOs should establish mechanisms to ensure ease of access and a reasonable level of responsiveness for each member to

their community-based case manager. MCO case managers are required to have knowledge of community alternatives for the target populations, as well as specialized knowledge of the conditions and functional limitations of the target populations served. In addition, the MCOs should ensure community-based case management is provided in a conflict free manner which separates the final approval of plans of care and the approval of funding amount by the MCO.

Of the documents reviewed, only contracts or RFPs established by Hawaii and New Mexico included ratios for the equivalent positions of case managers to members. Specifically, Hawaii's RFP required one service coordinator to 50 members and New Mexico's contract required one care coordinator to 75 members for Tier Level Two members and one care coordinator to 50 members for Tier Level Three members. None of the remaining contracts reviewed specify a ratio of community-based case Manager-to-Medicaid members. While, DHS does not prescribe required ratios for Iowa's MCOs, DHS reserves the right to require the MCOs to hire additional community-based case managers if it is determined, at the sole discretion of DHS, the MCOs have insufficient community-based case management staff to properly and timely perform the obligations under the contract. We inquired of DHS if they have exercised the right to require any of the MCOs to hire additional community-based case management staff and based on the responses from DHS staff, they replied "no." Other than Iowa and Tennessee, none of the contracts reviewed for other states included a provision which would provide the opportunity to require hiring additional case managers.

According to Iowa's MCO contracts, MCOs are required to make efforts to minimize the number of changes in a member's community-based case manager in order to ensure quality and continuity of care. Iowa's MCOs are to permit Medicaid members to change to a different community-based case manager if the member desires and there is an alternative community-based case manager available at the MCO. The MCO contracts do not address what is to happen if an alternative manager is not available.

The provisions of Iowa's MCO contracts require the community-based care managers to contact members either in person or by telephone on a monthly basis, and to visit the member in their residence face-to-face as frequently as necessary, but at least every three months (quarterly).

Table 2 summarizes whether or not other states have similar community-based case management contract provisions. None of the MCO contracts reviewed, including Iowa's, allow members to keep their case manager if they switch MCOs.

Table 2

	MCO Contracts Required:	
State	**Regular Face-to-Face Case Manager Meetings**	**Frequency of Meetings**
Iowa	***Yes***	***Quarterly***
Colorado	No	N/A
Hawaii[1]	Yes	Quarterly
Kansas	Yes	Quarterly
Kentucky	No	N/A
Maryland[1]	Yes	Not Defined
Minnesota	Yes	Monthly, or as Appropriate
Nebraska	Yes	As Appropriate
New Mexico	Yes	Quarterly
Ohio[1]	No	N/A
Oregon	No	N/A
Rhode Island	Yes	Not Defined
Tennessee	Yes	Quarterly
Washington[1]	No	N/A

[1] Individual MCO contracts are unavailable; model contracts/agreements were reviewed.

As illustrated by the **Table**, Iowa and eight other states reviewed, required regular face-to face case manager meetings for members receiving community-based services. Of the nine states requiring regular face-to-face meetings, only the State of Minnesota meets on a monthly basis with members. Of the remaining eight states, five, including Iowa, required members to meet face-to-face on a quarterly basis. For the remaining three states, the contracts did not identify a specific amount of time or stated face-to-face meetings were held as appropriate. Based on our review, Iowa's quarterly meeting requirements are reasonable and comparable to other states.

As previously stated, Iowa has experienced turnover in MCOs since the inception of the IA Health Link program. As an MCO has left the program, Medicaid participants assigned to the departing MCO are reassigned to an existing or incoming MCO. Iowa's contracts with the MCOs do not provide any provision regarding continuity of services provided by the MCOs' case managers. We contacted DHS to determine if DHS has established any provisions which ensure Medicaid members with intellectual, developmental disabilities, or other special needs are assigned a case manager from DHS who remains assigned to individual cases even when the Medicaid member is moved from one MCO to another. DHS representatives stated "DHS does not assign case managers that are employed by MCOs. The MCOs are responsible to determine case manager assignment. Members can change MCO's during initial enrollment, annual enrollment, or for good-cause." Based on the response from DHS staff, DHS does not provide a case manager to these individuals to ensure consistency of services when the individual has to switch MCOs.

Individualized Staffing

The contracts established by Iowa and the selected states require MCOs to maintain a level of staffing necessary to perform and carry out all functions, requirements, roles, and duties under the contract. In general, state agencies did not define the overall staffing levels of the MCO. However, the contracts contain provisions with state failure by an MCO to maintain compliance with the performance metrics of the contract may cause the state agency to require additional staffing obligations of the MCO in order to achieve compliance with contractual obligations.

A commonly addressed area in MCO contracts for staffing levels pertains to Medicaid members who require individual or enhanced staffing interaction in order to support the individual in a less restrictive setting, such as that which occurs with mental health and/or substance abuse services. In Iowa, the MCO contracts prohibit the contractors from arbitrarily reducing staff for individuals without clinical support for the staff reduction.

We reviewed other states' MCO contracts to determine if similar language was included. During our review, Iowa and Tennessee MCO contracts prohibited the MCOs from arbitrarily reducing staff for members receiving individualized care without clinical support for the reduction.

Coverage Protection for Medicaid Members

State agency and federal regulations specify the covered benefits and services deemed medically necessary which the MCOs are required to provide to their Medicaid members. In accordance with these regulations, MCOs are required to provide service coverage in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished.

In Iowa, Medicaid members have several benefit packages to choose from. In providing these benefits, Iowa's MCOs are prohibited from arbitrarily denying or reducing the amount, duration, and scope of a required service solely because of a diagnosis, type of illness, or condition, including a pre-existing condition, of the member.

During our review, we identified Iowa and 12 other states have included a contract provision to prohibited from arbitrarily denying or reducing the amount, duration, and scope of a required service solely because of a diagnosis, type of illness, or condition, including a pre-existing condition, of the member. The State of Minnesota did not include this provision in their MCO contracts.

Service Access Standards for Medicaid Members

As part of the provisions related to covered benefits, MCO contracts specifically address the accessibility of healthcare services and require contractors provide available, accessible, and adequate numbers of healthcare related facilities, professionals, and services to Medicaid member populations. More specifically, MCO contractors are held to distance and/or time standards regarding how accessible Medicaid members are to commonly utilized healthcare provider types. Provider types include, but are not limited to, primary care physicians, specialty care physicians, and hospitals, to include emergency services. In accessing these providers, MCO contracts establish standards for provider access for Medicaid members who reside in both urban and rural areas.

According to Iowa's MCO contracts, the contracts establish access standards for Medicaid members seeking treatment from primary care physicians, specialty physicians and hospital providers. For areas of the state where provider availability is insufficient to meet the established standards, such as in health professional shortage areas and medically underserved areas, the access standards set by the MCO contracts require they be the usual and customary standards for the affected community or area. Based on Iowa's MCO contracts, primary care providers should be within 30 miles for urban and rural Medicaid members. In addition, for specialty care providers, the distance identified by the contracts are 60 miles for urban and rural Medicaid members. The MCO contracts also state hospitals in urban areas should be within 30 miles and community standards for rural Medicaid members.

Based on the standards identified in Iowa's MCO contracts, we compared the distance or time standards to other states to determine if the standard was similar. **Table 3** summarizes the distance and/or time standards for primary care providers, specialty care providers and hospitals for the other states

Table 3

	MCO Contract Standards For:					
	Primary Care Providers		Specialty Care Providers		Hospitals	
State	Urban	Rural	Urban	Rural	Urban	Rural
Iowa	***30 miles***	***30 miles***	***60 miles***	***60 miles***	***30 miles***	***CS***
Colorado[2]	30 minutes	30 minutes or provider availability	30 minutes	30 minutes or provider availability	30 minutes	30 minutes or provider availability
Hawaii[1]	30 minutes	60 minutes	30 minutes	60 minutes	30 minutes	60 minutes
Kansas	20 miles	30 miles	30 miles	90 miles	30 miles	60 miles
Kentucky	30 miles	45 miles	60 miles	60 miles	30 miles	60 miles
Maryland[1]	10 miles	30 miles	15 miles	75 miles	10 miles	60 miles
Minnesota	30 miles	30 miles	60 minutes	60 minutes	30 minutes	30 minutes
Nebraska	30 miles	45 miles	90 miles	90 miles	30 minutes	30 minutes or CS
New Mexico	30 miles	45 miles	30 miles	60 miles	30 miles	60 miles
Ohio[1,3]	N/A	N/A	N/A	N/A	N/A	N/A
Oregon[3]	N/A	N/A	N/A	N/A	N/A	N/A
Rhode Island	20 miles	20 miles	30 miles	30 miles	30 miles	30 miles
Tennessee	20 miles	30 miles	60 miles	60 miles	30 miles	CS
Washington[1]	10 miles	25 miles	Contractor Established	Contractor Established	25 miles	25 miles

[1] Individual MCO contracts unavailable; model contracts/agreements reviewed.
[2] Standard for rural areas is based on the availability of providers.
[3] No time or distance standards found in these MCO contracts.
CS – Community Standard.

As illustrated by the **Table**, nine of the thirteen other states selected for review used distance. The remaining four states, including Colorado, Hawaii, Minnesota, and Nebraska, used a time standard for measurement for most or some of the categories identified above. When comparing Iowa's measurement of travel distance to the other nine states, the distance to primary care providers, specialty care providers, and hospitals was comparable with the distance specified in the other states' contracts.

Medicaid Member Grievance and Appeal Standards

Medicaid members receive a member handbook from DHS upon enrollment in the Medicaid program which describes the benefits and coverage to be provided in accordance with federal regulations. They also receive a handbook from the MCO they select or to which they are assigned. According to Iowa MCO contracts, the content of the member handbook includes information which helps the member to understand how to effectively use the managed care program. Iowa's MCO contracts require the member handbook includes, but not be limited to:

(1) the member's right to file grievances and appeals;

(2) the requirements and timeframes for filing a grievance or appeal;

(3) the availability of assistance in the filing process;

(4) the right to request a State fair hearing after the MCO has made a determination regarding a member's appeal which is adverse to the member; and

(5) the fact that, when requested by the member, benefits that the MCO seeks to reduce or terminate will continue if the member files an appeal or a request for DHS fair hearing within the timeframes specified for filing, and that the member may, consistent with DHS policy, be required to pay the cost of services furnished while the appeal or State fair hearing is pending if the final decision is adverse to the member.

According to Iowa's MCO contracts, grievance is defined "as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance also includes a member's right to dispute an extension of time proposed by an MCO to make an authorization decision."

In addition, according to Iowa's MCO contracts, appeal is defined as a review by the MCO of an adverse benefit determination. The MCO contracts also state no appeal is granted when a request for exception to policy, such as a request that exceeds service or reimbursement limits, has been denied by the MCO. According to Exhibit A (definitions) of the MCO contracts, an adverse benefit determination is defined as any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

- The reduction, suspension, or termination of a previously authorized service.

- The denial, in whole or in part, or payment for a service.

- The failure to provide services in a timely manner, as defined by DHS.

- The failure of the MCO to act within the timeframes provided in federal regulations and regarding the standard resolution of grievances and appeals.

- The denial of a member's request to dispute a financial liability including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial responsibilities.

The MCO contracts require the MCOs to have a grievance and appeal system in place for members. In addition, the Iowa MCO contracts state "State law permits a provider or an authorized

representative, with written consent of the member, to file a grievance or request an appeal, or request a State fair hearing, on behalf of a Medicaid member."

In accordance with federal regulations, Iowa's MCO contracts include requirements regarding how the MCOs handle grievances and appeals. According to Iowa's MCO contracts, the MCOs must provide Medicaid members with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. In addition, Iowa's MCOs contracts require MCOs to "acknowledge receipt of each grievance and appeal within three business days and ensure the individuals who make decisions on grievances and appeals are individuals who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual and have the appropriate clinical expertise, as determined by DHS, in treating the member's condition or disease." Also, according to the Iowa MCO contracts, MCOs are required to resolve each grievance and appeal and provide notice to the Medicaid member within DHS established timeframes.

Based on our review of Iowa's MCO contracts, we identified the following procedures relating specifically to handling of grievances and appeals:

- Grievances – A Medicaid member may file a grievance either orally or in writing with an MCO at any time. According to the Iowa MCO contracts, for standard resolution of a grievance, the MCOs should resolve and provide notice to the affected parties within 30 calendar days from the day the MCO received the grievance. However, the MCO may extend the timeframe by up to 14 calendar days if, (1) the Medicaid member requests an extension, or (2) the MCO shows, to the satisfaction of DHS, there is need for additional information and how the delay is in the member's interest. In addition, the MCOs are required to provide written notice of grievance resolutions to members.

- Appeals – According to the Iowa MCO contracts, following the receipt of a notification of an adverse benefit determination by an MCO, a Medicaid member has 60 calendar days from the date of the adverse benefit determination notice to file a request for an appeal to the MCO. A Medicaid member may request an appeal either orally or in writing. However, unless the member requested an expedited resolution, an oral appeal must be followed by a written, signed appeal.

  In accordance with the federal regulations and according to the Iowa MCO contracts, the MCO must use language developed by DHS for the notice of adverse benefit determination to the Medicaid member. According to the Iowa MCO contracts, the notice must explain the following:

  - The adverse benefit determination the MCO has made or intends to make.,

  - The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination.

  - The member's right to request an appeal of the MCO's adverse benefit determination, including information on exhausting the MCO's one level of appeal and the right to request a State fair hearing.

  - The procedures for exercising appeal rights.

  - The circumstances under which an appeal process can be expedited and how to request it.

- The member's rights to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with DHS policy, under which the member may be required to pay the costs of these services.

According to the Iowa MCO contracts, the MCOs are required to provide the Medicaid member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. In addition, the MCO must provide the member with the member's case file, including medical records, other documents and records, and any new or additional evidence considered relied upon, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and in advance of the resolution timeframe for appeals as specified in federal regulations.

Based on our review of the Iowa MCO contracts, for standard resolution of an appeal, the contract states the MCOs "shall resolve and provide notice to the affected parties within 30 calendar days from the day the MCO receives the appeal." However, if a member requests an expedited resolution of an appeal, the MCO "shall resolve and provide notice to the affected parties within 72 hours after the MCO receives the appeal. The MCO may extend the resolution timeframe by up to 14 calendar days if, (1) the Medicaid member requests an extension, or (2) the MCO shows, to the satisfaction of DHS, that there is need for additional information and how the delay is in the member's interest."

The Iowa MCO contracts also state the MCOs are required to provide written notice of appeal resolution to Medicaid members. According to the Iowa MCO contracts, the written notice must include:

- The results of the resolution process and the date it was completed.

- For appeals not resolved wholly in favor of the member, the written notice of appeal resolution must include:

  - The right of the member to request a State fair hearing and how to do so.

  - The right of the member to request and receive benefits while the hearing is pending and how to make the requests.

  - That the member may, consistent with DHS policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's adverse benefit determination.

Also, a Medicaid member may request a State fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination. A member must request a State fair hearing no later than 120 calendar days from the date of the MCO's notice of resolution.

We compared the Iowa MCO contract provisions regarding grievance and appeal standard provisions to the other selected states' contracts to determine if they contained similar requirements. All contracts reviewed included criteria for member grievances and appeals. **Table 4** summarizes the other states' criteria for member grievances, time standard for resolutions, time standards for appeals, and penalties for failure to timely resolves grievances or appeals.

Table 4

State	MCO Contracts: Time Standards for Grievance Resolution	Time Standards for Appeal Resolution	Establish Penalties for Failure to Timely Resolve Grievances or Appeals
Iowa	***30 days***	***30 days; 72 hrs. if expedited***	***Yes***
Colorado	15 days	45 days	Yes
Hawaii[1]	30 days	30 days	Yes
Kansas	30 days	30 days	Yes
Kentucky	30 days	30 days	No
Maryland[1]	30 days	30 days	No
Minnesota	30 days	30 days	No
Nebraska	90 days	45 days	No
New Mexico	30 days	30 days	Yes
Ohio[1]	30 days	15 days; 72 hrs. if expedited	Yes
Oregon	5 days; up to 30 days	14 days	Yes
Rhode Island	90 days	30 days	No
Tennessee	90 days	90 days	Yes
Washington[1]	45 days	14 days	No

[1] Individual MCO contracts were unavailable; model contracts/agreements were reviewed.

As illustrated by the **Table**, the State of Oregon has the shortest time standards for grievance and appeal resolutions of five days (up to 30 days) and 14 days, respectively. The State of Tennessee had the longest time standard for grievance and appeal resolution of 90 days for both. After comparing the State of Iowa to other states, we determined Iowa's time standards for grievance and appeal resolution is comparable to states which have similar contract requirements.

Exception to Contractor Policy

The Iowa MCO contracts contain a provision identified as "Exception to Contractor Policy." According to the Iowa MCO contracts, a Medicaid member can request an item or service which is not otherwise covered by the MCO, or the state agency, as part of covered benefits or services. The provision also states Iowa's MCOs are permitted to grant exceptions to policy for any MCO policies, but they cannot grant exceptions to policy to federal and state laws and regulations governing the Medicaid program. According to Iowa's MCO contracts, an exception to policy is considered a last resort request for a service or benefit by the member and is not appealable as the request is considered for services or benefits outside of the state plan or allowable coverage areas for Medicaid.

We reviewed other states' MCO contracts to determine if they allowed for an exception to policy for Medicaid member services. For the states reviewed, including Iowa, the MCO contracts did not include language specifically requiring the exception to policy for Medicaid member services. However, the contracts allowed the exceptions to be granted. As a result, Iowa's contract provision appears to be standard language when comparing Iowa to other states with similar demographics.

Timely Payment of Healthcare Provider Claims

The Iowa MCO contracts include requirements for MCOs to maintain claims processing systems to pay provider claims for the services provided to Medicaid members. The MCO claims processing systems are to include the ability to accept claims in electronic and paper form from both in-network and out-of-network providers. After the claims are accepted, MCOs are to pay or deny the submitted claims and MCOs are required to accurately pay claims for Medicaid members' periods of eligibility.

As part of the claims processing, MCOs are required to pay healthcare providers for covered medically necessary services rendered to Medicaid members in a timely manner. Iowa MCO contracts contain provisions to identify specific parameters for timely payment expectations of the MCOs, especially as they relate to "clean claims". As stated by the Iowa MCO contracts, a clean claim is one in which all information required for processing the claim is included on the claim for payment submitted by the healthcare provider.

In addition, the Iowa MCO contracts specifically address claims which are denied because more information was required to process the claim than was submitted by the healthcare provider. In these instances, the MCOs are required to issue a claim denial notice to the provider and specifically describe all information and supporting documentation needed by the MCO to evaluate the claim for processing. Iowa's MCO contracts have established timely payment standards for clean claims as well as all claims submitted by healthcare providers. Specifically, the following standards have been established for the timely payment of claims:

- Pay or deny 90 percent of clean claims within 30 calendar days of receipt;
- Pay or deny 95 percent of clean claims within 45 calendar days of receipt; and
- Pay or deny 99 percent of all claims within 90 calendar days of receipt.

To ensure timely claims payment standards are met, Iowa's MCO contract provisions include a liquidated damage clause if the MCOs fail to meet these performance requirements. In the event liquidated damages are imposed, Iowa's MCO contracts require the MCOs to provide DHS with a formal corrective action plan, as well as monthly reports on the identified deficiency until the deficiency is corrected, or for a period of 60 days. According to Iowa's MCO contracts, MCOs that fail to meet timely claims payments standards are subject to penalties, or liquidated damages of $5,474 per reporting period. Iowa's MCO contracts include a number of reporting periods for various requirements. However, the contracts do not specify the reporting periods referred to when addressing penalties or liquidated damages.

We compared the standards identified in Iowa MCO contracts to those included in other states' MCO contracts to determine if they identified payment standards and penalties for lack of timeliness of payments similar to Iowa. **Table 5** summarizes the contract language provisions for payment standards and penalty standards.

Table 5

State	Payment Adjudication Standards for Clean Claims: First Standard	Second Standard	Third Standard	Penalties if Timeliness Not Met
Iowa	***90% w/in 30 days***	***95% w/in 45 days***	***99% w/in 90 days***	***Yes***
Colorado	90% w/in 30 days	99% w/in 90 days	--	No
Hawaii[1]	90% w/in 30 days	99% w/in 90 days	--	Yes
Kansas	100% w/in 30 days	--	--	Yes
Kentucky	90% w/in 30 days	99% w/in 90 days	--	Yes
Maryland[1]	w/in 30 days	--	--	No
Minnesota	w/in 30 days	--	--	No
Nebraska	90% w/in 15 days	99% w/in 60 days	--	No
New Mexico	90% w/in 30 days	99% w/in 90 days	--	Yes
Ohio[1]	90% w/in 30 days	99% w/in 90 days	--	Yes
Oregon	90% w/in 30 days	99% w/in 90 days	--	No
Rhode Island	w/in 30 days	--	--	No
Tennessee	90% w/in 30 days	99.5% w/in 60 days	--	Yes
Washington[1]	95% w/in 30 days	99% w/in 90 days	--	No

[1] Individual MCO contracts unavailable; model contracts/agreements reviewed.

As illustrated by the **Table**, we identified four states which identified the payment standard for clean claims be all paid within30 days. The remaining ten states, including Iowa, required 90%-95% of clean claims be paid within 15 to 30 days. However, of the ten states, nine states had a contract provision stating 99% to 99.5% of clean claims be paid within 60 to 90 days. Iowa was the only state we reviewed whose MCO contracts identified three standards for payment of clean claims. However, Iowa's third payment standards is similar to the second standard for the ten other states we reviewed who had more than one payment standard. Also as illustrated by the **Table**, seven of the states we reviewed, including Iowa, had contract provisions included which allowed penalties to be imposed if timeliness of payment standards were not met.

In addition to payment standards for clean claims, Iowa's MCO contracts also established timely payment standards for adjusted and reprocessed claims. During our review of Iowa's MCO contracts, the following standards were established for the payment of adjusted and reprocessed claims:

- For claims adjusted and resubmitted by healthcare providers, the MCO is required to pay or deny 90% of all clean claims within 30 business days of receipt; and
- For claims originally processed in error by the MCO, all claims are required to be reprocessed within 30 business days of identification of the error or upon a DHS approved schedule.

We compared Iowa's MCO contract provisions to other states to determine if their contracts included language for adjusted and reprocessed claims and if it was similar to Iowa's MCO contracts. **Table 6** summarizes whether or not adjusted or reprocessed claims contract language was included and the standards of payment.

Table 6

State	MCO Contract Payment Adjudication Standards for: Provider Adjusted Claims	Reprocessed Claims due to MCO Error
Iowa	***90% w/in 30 days***	***All w/in 30 days of error***
Colorado	None	None
Hawaii[1]	None	None
Kansas	100% w/in 30 days	No Time Requirement
Kentucky	None	None
Maryland[1]	None	None
Minnesota	None	None
Nebraska	None	None
New Mexico	None	None
Ohio[1]	None	All w/in 60 days of error
Oregon	None	None
Rhode Island	None	W/in 30 days
Tennessee	None	None
Washington[1]	None	None

[1] Individual MCO contracts unavailable; model contracts/agreements reviewed.

As illustrated by the **Table**, Iowa and Kansas both have contract provisions addressing payment standards for provider adjusted claims. In addition, Iowa, Kansas, Ohio, and Rhode Island are the only states reviewed which have contract provisions for payment standards with reprocessing claims. When comparing Iowa's MCO contracts to other states for these two contract provisions, Iowa's MCO contracts are more specific in the requirements imposed than the majority of the other states we reviewed.

Incurred But Not Yet Reimbursed Claims

According to federal regulations, MCOs are required to maintain a health information system which collects, analyzes, integrates, and reports data and can achieve the program objectives. The health information system's basic elements should include the ability to ensure that data received from providers is accurate and complete. In order to achieve this objective, the health information system must:

- verify the accuracy and timeliness of reported data;
- screen the data for completeness, logic, and consistency; and
- collect the data from providers in standardized formats to the extent feasible.

MCOs health information systems are specifically required to maintain capabilities related to Medicaid member encounter data. According to the Iowa MCO contracts, MCOs are required to:

- collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members,
- submit member encounter data to the state agency at a frequency and level of detail to be specified by the Centers for Medicare and Medicaid Services (CMS) and the state agency, based on program administration, oversight, and program integrity needs, and
- submit all member encounter data that the state agency is required to report, in the appropriate specifications and format, to CMS per federal regulations.

Iowa's MCO contracts require the MCOs to perform numerous health information system functions which integrate the MCOs' clinical record information, authorization, and claims payment data. Specifically, Iowa's MCO health information systems are required to maintain data on claims for payment by healthcare providers that have been incurred but not yet reimbursed by the MCOs.

We reviewed other states MCO contracts to determine if their contracts included a provision on claims for payment by healthcare providers that have been incurred by the MCOs, but not yet reimbursed. Iowa was the only state which included a provision in the MCO contracts addressing the requirement for MCOs to maintain data for claims incurred, but not yet reimbursed. Based on our review of the other states' contracts, we were unable to identify a similar requirement. As a result, Iowa's MCO contracts have a requirement other selected states did not include in their MCO contracts. The requirement of MCOs to maintain data regarding claims incurred but not yet reimbursed allows the State the opportunity to review the timeliness of payments and amounts of outstanding claims at any given point which allows DHS to have better oversight.

Because we determined other states did not include language specifically related to incurred but not yet reimbursed claims, we inquired of DHS staff why Iowa's MCO contracts included this language. DHS staff responded to our inquiry with a definition of incurred but not reported rather than why Iowa's MCO contracts had a contract provision. As a result, we were not able to determine why DHS officials included it in Iowa's MCO contracts.

As previously stated, federal regulations require MCOs to maintain a health information system which collects, analyzes, integrates, and reports data and can achieve the program objectives. The health information system's basic elements should include the ability to ensure that data received from providers is accurate and complete. In order to achieve this objective, the health information system must collect the data from providers in standardized formats to the extent feasible. However, Iowa MCO contracts do not require a standardized system to be used by the MCOs. To improve accuracy and efficiency, DHS should require MCOs to use similar coding mechanisms for claims. A standardized coding system would help achieve efficiencies by providers preparing claims, by the MCO processing claims, and by DHS during oversight procedures.

Encounter Data Reporting

The MCO model for Medicaid requires MCOs to submit to their respective state agencies an "encounter claim" for every service rendered to a Medicaid member for which the contractor either paid or denied the healthcare provider's claim for reimbursement. As with Fee-for-Service type claims, encounter claims contain information such as the procedure(s) performed, diagnoses, place of service, units of service, billed amounts, reimbursement amounts, and providers' identification numbers.

According to the Iowa MCO contracts, MCOs are required to report all encounter information to DHS as part of state agency oversight. In addition, the Iowa MCO contracts require the MCOs to implement policies and procedures to ensure encounter claims submissions are accurate and available for regular review and monitoring by DHS. Iowa's MCO contracts also permit DHS to perform an audit of encounter claims as requested.

We reviewed the other states' MCO contracts to determine if they include a provision regarding encounter data maintenance, availability, and accuracy. All of the states reviewed had provisions or standards in their MCO contracts which required MCOs to monitor and ensure encounter data submitted was accurate. In addition, all the state contracts reviewed require the MCOs to submit encounter data to the appropriate state agencies and include requirements for the state agencies to monitor MCO policies and procedures for encounter data and perform quarterly reviews of the encounter data submitted.

Pharmacy Benefits and Services

Iowa's MCO contracts provide for coverage of prescription drugs to Medicaid members in accordance with applicable federal and state laws. According to the contracts, MCOs are required to provide coverage for all classes of drugs, including over-the-counter drugs, to the extent and manner they are covered by the Medicaid fee-for-service pharmacy benefit.

The contracts state MCOs are required to utilize State procedures and adhere to designated prescribing practices in providing prescription drug coverage. As a result, Iowa's MCO contracts specify the MCOs are to utilize preferred and recommended drug lists and ensure appropriate use of medications through a prior authorization program. Iowa's MCO contracts also provide specific guidance to the MCOs on reimbursement rates for pharmacy services by requiring the MCOs to reimburse providers at a rate comparable to the effective Medicaid Fee-for-Service rates for both the drugs, as well as the dispensing fees.

Iowa's MCO contracts address provisions established by the Federal 340B Drug Pricing program. This program, managed by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Office of Pharmacy Affairs, allows certain designated facilities to purchase prescription medications at discounts, so these facilities can offer these medications to their patients at reduced prices. Since 340B drugs are discounted drugs, Iowa's MCOs are required to ensure 340B covered entities use 340B drugs and serve Medicaid managed care enrollees adhere to proper billing procedures for services to Medicaid MCO members. As such, Iowa's MCOs should ensure either:

- the 340B covered entity only uses non-340B drugs, vaccines, and diabetic supplies for all Iowa Medicaid managed care enrollees served under a carve out program. In these cases, the MCO should ensure the provider only bills the MCO for drugs purchased outside the 340B program. OR:
- the 340B covered entity uses 340B drugs for all Iowa Medicaid managed care members, informs the HRSA of this intention, and submits its pharmacy claim forms to the MCO with proper field values to identify the drugs as 340B acquired drugs.

For pharmacies which contract with HRSA to dispense 340B drugs, Iowa's MCO contracts require the MCOs to ensure pharmacies using 340B drugs carve out Iowa Medicaid managed care prescriptions from the 340B program and only bill the MCOs for drugs purchased outside the 340B program.

As part of pharmacy monitoring responsibilities, Iowa's MCO contracts require the MCOs to administer a drug utilization program and include a prospective review process for all drugs prior to dispensing. In addition, a retrospective drug utilization review process should be administered to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse of prescription drugs. According to Iowa's MCOs contracts, MCOs are required to educate Medicaid members as part of drug utilization management in order to correct overutilization and underutilization, as well as educate healthcare providers on specific medications, at a minimum, as requested by the State.

We compared the MCO contracts of other states to Iowa's MCO contracts for the following contract provisions:

- usage of State procedures and prescribing practices,
- specific guidance on pharmacy reimbursement rates,
- addressed proper billing of 340B prescription drugs,
- required utilization review to detect inappropriate drug use or abuse, and
- required member and provider education to ensure appropriate drug utilization.

Table 7 summarizes the other states contracts compared to Iowa's MCO contracts for the provision identified above.

Table 7

State	MCO Contracts: Require Usage of State Procedures and Prescribing Practices	Provide Specific Guidance on Pharmacy Reimbursement Rates	Address Proper Billing of 340B Drugs	Require Utilization Review to Detect Inappropriate Drug Use or Abuse	Require Member/Provider Education to Ensure Appropriate Drug Utilization
Iowa	***Yes***	***Yes***	***Yes***	***Yes***	***Yes***
Colorado	Yes	No	Yes	Yes	No
Hawaii[1]	Yes	No	Yes	Yes	Yes
Kansas	Yes	Yes	Yes	Yes	Yes
Kentucky	Yes	Yes	Yes	Yes	Yes
Maryland[1]	Yes	No	Yes	Yes	No
Minnesota	Yes	No	Yes	Yes	Yes
Nebraska	Yes	Yes	Yes	Yes	Yes
New Mexico	Yes	Yes	No	Yes	Yes
Ohio[1]	Yes	Yes	Yes	Yes	Yes
Oregon	Yes	No	No	Yes	Yes
Rhode Island	Yes	No	Yes	Yes	Yes
Tennessee[2]	N/A	N/A	No	Yes	Yes
Washington[1]	Yes	No	No	Yes	Yes

[1] Individual MCO contracts unavailable; model contracts/agreements reviewed.

[2] State of Tennessee separately contracts with pharmacy benefit manager.

As illustrated by the **Table**, a majority of the other states MCO contracts included provisions for requiring usage of state procedures and prescribing practices, reimbursements rates, and addressed properly billing of 340B prescription drugs. In addition, majority of the states required utilization review to detect inappropriate drug use and abuse and requiring members and providers to receive education to ensure appropriate drug utilization. However, there were seven states which did not provide specific guidance on pharmacy reimbursement rates. In addition, the contracts/agreements for four states did not address proper billing of 340B drugs. Also, Colorado and Maryland's contracts/agreements did not require member and/or provider education to ensure appropriate drug utilization. As a result, Iowa MCO contracts have the similar contract provisions as a several of the other states reviewed.

Pharmacy Benefit Administration

To provide for coverage and administration of pharmacy benefits and services, MCOs may subcontract with a separate entity, or Pharmacy Benefit Manager (PBM) to carry out the MCO's prescription drug coverage requirements. Iowa's MCO contracts required the MCOs to utilize a PBM to be responsible for processing prescription claims online through a real-time point of sale system. Even though the PBMs are a subcontractor to the MCOs, DHS required the PBMs be directly available to DHS staff.

According to the Iowa MCO contracts, MCOs are required to obtain DHS approval for the subcontracted PBMs. All PBM ownership information must be submitted to DHS prior to approval of the PBM subcontract. If a PBM is owned wholly or in part by a retail pharmacy provider, chain drug store, or pharmaceutical manufacturer, the MCO is required to provide DHS with written assurance and procedures that should be put in place under the PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflict of interest exists, and to ensure the confidentiality of proprietary information. In addition, Iowa's MCOs are required to provide a plan to DHS documenting how the MCOs will monitor and conduct oversight of the PBM activities and performance during the contract period.

We reviewed other states' MCO contracts to determine if their contracts included a provision for the use of PBMs. In addition, if the use of PBMs were required or allowable, we reviewed the contracts to determine if additional information, such as ownership and performance reviews of the MCOs were detailed in the MCO contracts.

There are three states, including Iowa, which required the use of a PBM for prescription drugs for the period of our review. Of the three states, Iowa and Nebraska required PBM ownership information be provided to the appropriate state agency for review. In addition, Iowa and Nebraska required the MCOs to provide procedures on how the MCO will monitor the PBMs with potential conflict of interest and how the MCO will monitor and conduct oversight of the PBMs activities and performance. Based on our review, Iowa was one of the few states that required the MCOs to utilize a PBM; however, because Iowa utilized a PBM, Iowa did a good job ensuring the contract included language to address conflict of interest and monitoring performance.

Drug Manufacturer Rebates

Through drug manufacturer agreements between the U.S. Department of Health and Human Services, or with individual states, drug manufacturers provide payments to state Medicaid programs for certain drugs that are utilized by Medicaid members. These payments by drug manufacturers are known as "drug rebates". Federal regulations require Medicaid to cover all drugs in which drug manufacturers offer a rebate, with the exception of drugs that are subject to restrictions.

Iowa's MCO contracts prohibit the MCOs, as well as pharmacy benefit managers (PBMs), from obtaining drug manufacturer rebates. According to Iowa's MCO contracts, Section 1927(b) of the Social Security Act, as amended by Section 2501(c) of the Patient Protection and Affordable Care Act, P.L. 111-148, require DHS to provide drug utilization information for drugs covered by the MCOs to drug manufacturers via quarterly rebate invoices. DHS was also required to report this drug utilization information in quarterly reports to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. To comply with these quarterly reports, Iowa's MCOs are required to submit all drug encounters, including physician administered drugs, with the exception of inpatient hospital drug encounters, to DHS. After DHS receives the drug encounter information from the MCOs, DHS submits these encounters to the drug manufacturers for rebate collection.

We reviewed other states' MCO contracts to determine if their contracts included a provision which prohibits MCOs and subcontracts, such as PBMs, from obtaining drug rebates. In addition, we reviewed other states' MCO contracts to determine if they require MCOs to submit information or encounter data to the appropriate state agency for rebate collection.

The majority of the states reviewed, including Iowa, prohibit MCOs and subcontractors, such as PBMs, from obtaining drug rebates. In addition, the majority of the states require MCOs submit information or encounter data for drugs to the appropriate state agency for the completion of their quarterly reports and rebate collections. As a result, Iowa's MCO contracts have similar contract provisions related to drug rebates as the other states we reviewed.

Member/Provider Call Centers and Helplines

MCOs are to maintain call centers and/or helplines for Medicaid members which are to be staffed with trained personnel who are knowledgeable about their respective states' Medicaid programs and equipped to handle a variety of member inquires. MCOs are also to maintain call centers and/or helplines to address the needs of their provider networks.

Iowa's MCO contracts require member services helpline staff to be capable of responding to member concerns or issues including, but not limited to:

- how to access healthcare services;
- identification or explanation of covered services;

- procedures for submitting a grievance or appeal;
- reporting fraud or abuse;
- locating a provider,
- health crises to include suicidal callers;
- billing issues,
- cost-sharing and patient liability inquiries; and
- incentive programs.

In addition, Iowa's MCO contracts require provider services helplines to be capable of addressing all provider questions, concerns, and complaints.

While Iowa's MCO contracts establish member/provider call centers and helplines, there is no provision in the MCO contracts requiring these call centers and helplines be located within the State of Iowa. We reviewed other states' contracts to determine if they require call centers to be located within the state.

New Mexico and Ohio require the call center and/or hotline to be located within the State. The remaining states reviewed did not have a provision included in the contracts/agreements requiring call centers and/or hotlines be located within the State. It seems there would be an added benefit to having a call center and/or hotline required to be located in the State, such as no potential time delays due to different time zones resulting in a quicker response. It is unclear why this requirement would not be included in the contract.

State Income Taxes on Managed Care Organizations

Iowa's MCO contracts, as do MCO contracts in other states selected for comparisons, treat MCOs as independent contractors. As a result, MCOs, their employees, agents, and any subcontractors are not employees or agents of the State (DHS) simply by virtue of the work the MCOs perform pursuant to the contracts.

Because MCOs are conducting business in the state, there would be potential tax obligations due to the State. As a result, we reviewed Iowa's MCO contracts to determine if the contracts included language regarding taxes. During our review we determined the MCO contracts do not include provisions which explicitly require the MCOs to pay state income taxes. However, the contracts specify the State of Iowa is not responsible for any reports, payments, and withholdings regarding taxes and fees for which the MCOs may be subjected and required to pay in order to conduct business in the State of Iowa.

We reviewed other states' MCO contracts to determine if MCOs are subject to state income taxes. The contracts we reviewed for a majority of the states, including Iowa, include provisions documenting MCOs are subject to state income tax. As a result, Iowa's MCO contracts are similar to other states with similar demographics.

Minority and Women Owned Businesses

States entered into contracts with MCOs and included in their standard contract language requirements for MCOs, as well as any subcontractor, adherence and/or compliance with applicable federal and state laws and regulations. These applicable federal and state laws and regulations include anti-discrimination, equal employment opportunity, and environmental laws. A law that is specifically addressed in MCO contracts requires MCOs to take all necessary affirmative steps to assure minority and women owned businesses are used, when possible, as a source of any services purchased under the contract.

Iowa's MCO contracts require, in general terms, MCOs and subcontractor comply with all applicable federal, state, and local laws, rules, ordinances, regulations, orders, guidance and policy. Such applicable laws include, without limitation, all laws that pertain to the prevention of

discrimination in employment and in the provision of services such as equal employment opportunity, affirmative action, and the use of targeted small businesses as subcontractors or suppliers. Iowa's MCO contracts do not specifically mention the usage of minority and women owned businesses as part of its compliance provisions.

We reviewed other states' MCO contracts and compared them to Iowa. Of the MCO contracts we reviewed, four states included provisions requiring the use of minority and women owned businesses. However, the remaining states, including Iowa, had contract language which was more generic, such as "all laws that pertain to the prevention of discrimination in employment and in the provision of services. For employment, this would include equal employment opportunity and affirmative action and use of targeted small businesses as subcontractors or suppliers." As a result, Iowa's MCO contracts address prevention of discriminatory practices.

Healthcare Effectiveness Data and Information Set

The National Committee for Quality Assurance (NCQA) maintains the most widely used set of standardized performance measures utilized in the managed care industry. These performance measures, known as the Healthcare Effectiveness Data and Information Set (HEDIS), are designed to allow reliable comparison of performance of managed care plans so healthcare purchasers understand the value of health purchases by measuring plan performance.

HEDIS includes more than 90 performance measurements across six domains of care. These domains are:

- effectiveness of care;
- access/availability of care;
- experience of care;
- utilization and risk adjusted utilization;
- health plan descriptive information; and
- measures collected using electronic clinical data systems.

The NCQA collects HEDIS data from health plans and other health care organizations. Audits are performed of this data to protect the validity and reliability of the results. NCQA screens, trains, and certifies organizations that collect or audit data for health plans and providers.

Iowa's MCO contracts require the MCOs to conduct an annual HEDIS audit survey and submit the compliance auditor's final audit report and audited data for HEDIS in order to establish MCO performance. In addition, Iowa's MCO contracts include a pay for performance provision established by DHS for which the MCOs may receive compensation if certain conditions are met. Eligibility for compensation under the pay for performance program is subject to the MCO's complete and timely satisfaction of its obligations under the contract. During our review, we determined one of the pay for performance measures pertains to the NCQA/HEDIS domain "access/availability of care" and it assesses the access to care and preventative health utilization for children and adults.

We reviewed other states' MCO contracts to determine if their contracts included a provision which included the HEDIS score in performance measurers and if pay incentives were linked to the HEDIS performance score. All of the states' contracts we reviewed included the HEDIS score in the performance measurement. However, only six of the states, including Iowa, provided pay incentives which were linked to the HEDIS performance scores. As stated previously, Iowa's contract stated MCOs may receive compensation if certain conditions are met.

We inquired of DHS staff if incentive pay was received by Iowa MCOs based on the HEDIS performance and according to DHS staff, "pay for performance for contract year 1 (April 1, 2016 thru [sic] June 30, 2017) does not have performance measures related/tied to HEDIS." However,

DHS staff provided a payment summary for contract year 2 (July 1, 2017 through June 30, 2018). **Table 8** summarizes the payment summary provided by DHS staff.

Table 8

	AmeriHealth		Amerigroup		UnitedHealthcare	
Description	**Available**	**Earned**	**Available**	**Earned**	**Available**	**Earned**
Value Based Purchasing	$ 1,790,248.65	-	3,728,698.49	3,728,698.49	5,809,784.38	5,809,784.38
Children's Access to Care	1,790,248.65	1,790,248.65	3,728,698.49	3,728,698.49	5,809,784.38	5,809,784.38
Adult Access to Care	1,790,248.65	1,790,248.65	3,728,698.49	3,728,698.49	5,809,784.38	5,809,784.38
Provider Network – PCP and BHP	1,790,248.65	1,790,248.65	3,728,698.49	3,728,698.49	5,809,784.38	5,809,784.38
Appeals	1,790,248.65	1,790,248.65	3,728,698.49	3,728,698.49	5,809,784.38	-
Provider Network – HCBS	1,175,179.25	1,175,179.25	538,258.65	538,258.65	1,783,622.41	1,783,622.41
Maternity Kick Payments	1,128,670.40	339,447.35	670,950.05	670,950.05	1,161,612.65	1,115,162.80
Hawki	164,699.40	164,699.40	416,987.18	416,987.18	N/A	N/A
Total	$ 11,419,792.30	8,840,320.60	20,269,688.33	20,269,688.33	31,994,156.96	26,137,922.73

N/A – UnitedHealthcare did not calculate separately

According to DHS staff, DHS is currently reviewing the performance measurement findings for July 1, 2018 through June 30, 2019. A final report and payment information will be available by the end of July. Based on the other states' comparison, the incentive pay does not appear to be standard MCO contract language

Conclusion

Based on the procedures we performed, we determined the MCO contracts established by Iowa do not significantly vary from the contracts/agreements established by other states selected for review. The differences between Iowa's MCO contracts and those established by other selected states for certain provisions are summarized in **Schedule 2**.

However, the contracts established by Iowa included certain criteria that were not typically included in the other selected states' contracts/agreements, such as a

- prohibited arbitrary reduction of MCO staff who serve members that require individualized care without a clinical reason
- established penalties for failure to timely resolve grievances and appeals,
- required penalties if adjudication standards were not met,
- included a provision requiring MCOs to maintain data on IBNR,
- provided specific guidance on pharmacy reimbursement rates,
- required the usage of a Pharmacy Benefit Manager (PBM),
- prohibited MCOs and subcontractors (i.e. PBMs) from obtaining rebates, and
- required MCOs submit drug encounter data to State agencies for rebates collection.

Each of these criteria appear to incentivize MCOs for efficient administration of the Medicaid program and/or facility DHS' monitoring and oversight of the MCO operations.

A Review of
Managed Care Organization Contracts
Established by the
Iowa Medicaid Enterprise
Within the
Department of Human Services

Schedules

Schedule 1

A Review of Managed Care Organization Contracts
Established by the Iowa Medicaid Enterprise
Within the Department of Human Services

List of Contracts Reviewed by State
For the period April 1, 2016 Through July 31, 2019

State	MCO Contract(s) Reviewed
Iowa	Amerigroup Iowa
	AmeriHealth Caritas Iowa
	UnitedHealthcare Plan of the River Valley
	WellCare of Iowa
	Iowa Total Care
Colorado	Denver Health Medicaid Choice
	Rocky Mountain Health Plans Prime
Hawaii	MCO Request for Proposal Language
Kansas	Aetna Better Health of Kansas
	Sunflower Health Plan
	UnitedHealthcare Community Plan of Kansas
Kentucky	Aetna Better Health of Kentucky
	Anthem Blue Cross Blue Shield
	Humana CareSource
	Passport Health Plan
	WellCare of Kentucky
Maryland	Current Standard MCO Agreement
Minnesota	Blue Plus
	HealthPartners
	Hennepin Health
	Itasca Medical
	PrimeWest Health
	South Country Health Alliance
	UCare
	Medica
Nebraska	Nebraska Total Care
	UnitedHealthcare Community Plan of Nebraska
	WellCare of Nebraska

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List of Contracts Reviewed by State
For the period April 1, 2016 Through July 31, 2019

State	MCO Contract(s) Reviewed
New Mexico	BlueCross BlueShield of New Mexico
	Molina Healthcare of New Mexico
	Presbyterian Health Plan
	UnitedHealthcare of New Mexico
	Western Sky Community Care
Ohio	Standard MCO Managed Care Agreement
Oregon	Advanced Health
	AllCare CCO
	Cascade Health Alliance
	Columbia Pacific Coordinated Care Organization
	Eastern Oregon Coordinated Care Organization
	Health Share of Oregon
	InterCommunity Health Network Coordinated Care Organization
	Jackson Care Connect
	PacificSource Community Solutions Coordinated Care Organization Central Oregon Region
	PacificSource Community Solutions Coordinated Care Organization Columbia Gorge Region
	PrimaryHealth
	Trillium Community Health Plan
	Umpqua Health Alliance
	Willamnette Valley Community Health
	Yamhill Community Care
Rhode Island	Neighborhood Health Plan of Rhode Island
	UnitedHealthcare Community Plan
	Tufts Health Plan
Tennessee	Amerigroup
	BlueCare
	UnitedHealthcare Community Plan
	TennCare Select
Washington	Model MCO Contract

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Summary of State MCO Contract Provision Comparisons
For the period April 1, 2016 Through July 31, 2019

MCO contracts:	Iowa	Colorado	Hawaii*	Kansas
Early and Periodic Screening, Diagnosis and Treatment Services:				
Include member education on EPSDT services	Yes	Yes	Yes	Yes
Include provider education on EPSDT services	Yes	Yes	Yes	Yes
Community-Based Case Management:				
Require keeping case manager if member switches MCOs	No	No	No	No
Require regular face-to-face case manager meetings	Yes	No	Yes	Yes
Frequency of meetings	Quarterly	N/A	Quarterly	Quarterly
Individualized Staffing:				
Prohibit arbitrary staff reduction	Yes	No	No	No
Coverage Protection for Medicaid Members:				
Prohibit denying or reducing coverage due to diagnosis, illness or patient condition	Yes	Yes	Yes	Yes
Service Access Standards for Medicaid Members:				
Primary Care Providers - Urban	30 miles	30 minutes	30 minutes	20 miles
Primary Care Providers - Rural	30 miles	30 minutes or provider availability	60 minutes	30 miles
Specialty Care Providers - Urban	60 miles	30 minutes	30 minutes	30 miles

Kentucky	Maryland*	Minnesota	Nebraska	New Mexico	Ohio	Oregon	Rhode Island	Tennessee	Washington*
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
No	No	No	No	No	No	No	No	No	No
No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No
N/A	Not Defined	Monthly or as Appropriate	As Appropriate	Quarterly	N/A	N/A	Not Defined	Quarterly	N/A
No	No	No	No	No	No	No	No	Yes	No
Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
30 miles	10 miles	30 miles	30 miles	30 miles	N/A	N/A	20 miles	20 miles	10 miles
45 miles	30 miles	30 miles	45 miles	45 miles	N/A	N/A	20 miles	30 miles	25 miles
60 miles	15 miles	60 minutes	90 miles	30 miles	N/A	N/A	30 miles	60 miles	Contractor Established

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Summary of State MCO Contract Provision Comparisons
For the period April 1, 2016 Through July 31, 2019

MCO contracts:	Iowa	Colorado	Hawaii*	Kansas
Specialty Care Providers - Rural	60 miles	30 minutes or provider availability	60 minutes	90 miles
Hospitals - Urban	30 miles	30 minutes	30 minutes	30 miles
Hospitals - Rural	Community Standard	30 minutes or provider availability	60 minutes	60 miles
Medicaid Member Grievance and Appeal Standards:				
Establish criteria for grievances and appeals	Yes	Yes	Yes	Yes
Time standards for grievance resolution	30 days	15 days	30 days	30 days
Time standards for appeal resolution	30 days; 72 hours if expedited	45 days	30 days	30 days
Establish penalties for failure to timely resolve grievances and appeals	Yes	Yes	Yes	Yes
Exception to Contractor Policy				
Require exception to policy provision for member services	No	No	No	No
Timely Payment of Healthcare Provider Claims:				
First Payment Adjudication Standard	90% w/in 30 days	90% w/in 30 days	90% w/in 30 days	100% w/in 30 days

Kentucky	Maryland*	Minnesota	Nebraska	New Mexico	Ohio	Oregon	Rhode Island	Tennessee	Washington*
60 miles	75 miles	60 minutes	90 miles	60 miles	N/A	N/A	30 miles	60 miles	Contractor Established
30 miles	10 miles	30 minutes	30 minutes	30 miles	N/A	N/A	30 miles	30 miles	25 miles
60 miles	60 miles	30 minutes	30 minutes or community standard	60 miles	N/A	N/A	30 miles	Community Standard	25 miles
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
30 days	30 days	30 days	90 days	30 days	30 days	5 days; up to 30 days	90 days	90 days	45 days
30 days	30 days	30 days	45 days	30 days	15 days; 72 hours if expedited	14 days	30 days	90 days	14 days
No	No	No	No	Yes	Yes	Yes	No	Yes	No
No	No	No	No	No	No	No	No	No	No
90% w/in 30 days	W/in 30 days	W/in 30 days	90% w/in 15 days	90% w/in 30 days	90% w/in 30 days	90% w/in 30 days	W/in 30 days	90% w/in 30 days	95% w/in 30 days

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Summary of State MCO Contract Provision Comparisons
For the period April 1, 2016 Through July 31, 2019

MCO contracts:	Iowa	Colorado	Hawaii*	Kansas
Second Payment Adjudication Standard	95% w/in 45 days	99% w/in 90 days	99% w/in 90 days	-
Third Payment Adjudication Standard	99% w/in 90 days	-	-	-
Require penalties if adjudication standards not met	Yes	No	Yes	Yes
Provider adjusted claims adjudication standard	90% w/in 30 days	None	None	100% w/in 30 days
Reprocessed claims standard due to MCO error	All w/in 30 days of error	None	None	No Time Requirement
Incurred But Not Yet Reimbursed Claims (IBNR)				
Include a provision requiring MCOs to maintain data on IBNR	Yes	No	No	No
Encounter Data Reporting:				
Require MCOs to monitor encounter data and ensure accuracy to State agency	Yes	Yes	Yes	Yes
Require State agency review of encounter data and MCO policies and procedures	Yes	Yes	Yes	Yes
Pharmacy Benefits and Services:				
Require usage of State procedures and prescribing practices	Yes	Yes	Yes	Yes
Provide specific guidance on pharmacy reimbursement rates	Yes	No	No	Yes
Address proper billing of 340B prescription drugs	Yes	Yes	Yes	Yes
Require utilization review to detect inappropriate drug use or abuse	Yes	Yes	Yes	Yes
Require member and provider education to ensure appropriate drug utilization	Yes	No	Yes	Yes

Kentucky	Maryland*	Minnesota	Nebraska	New Mexico	Ohio	Oregon	Rhode Island	Tennessee	Washington*
99% w/in 90 days	-	-	99% w/in 60 days	99% w/in 90 days	99% w/in 90 days	99% w/in 90 days	-	99.5% w/in 60 days	99% w/in 90 days
-	-	-	-	-	-	-	-	-	-
Yes	No	No	No	Yes	Yes	No	No	Yes	No
None	None	None	None	None	None	None	None	None	None
None	None	None	None	None	All w/in 60 days of error	None	W/in 30 days	None	None
No	No	No	No	No	No	No	No	No	No
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes
Yes	No	No	Yes	Yes	Yes	No	No	N/A	No
Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	No
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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Summary of State MCO Contract Provision Comparisons
For the period April 1, 2016 Through July 31, 2019

MCO contracts:	Iowa	Colorado	Hawaii*	Kansas
Pharmacy Benefit Administration:				
Require the usage of a Pharmacy Benefit Manager (PBM)	Yes	No	No	No
Require PBM ownership information be provided to State agency	Yes	N/A	N/A	N/A
Require MCO monitor and provide oversight of PBM activities and performance	Yes	N/A	N/A	N/A
Drug Manufacturer Rebates:				
Prohibit MCOs and subcontractors (i.e. PBMs) from obtaining rebates	Yes	Yes	Yes	No
Require MCOs submit drug encounter data to State agencies for rebates collection	Yes	Yes	Yes	No
Member/Provider Call Centers and Helplines:				
Require call centers and helplines to be located within the State	No	No	No	No
State Income Taxes on Managed Care Organizations:				
Subject MCOs to State Income Taxes	Yes	Yes	Yes	Yes
Minority and Women Owned Businesses:				
Specifically require compliance with minority and women owned business laws	No	Yes	No	No
Healthcare Effectiveness Data and Information Set (HEDIS):				
Include HEDIS score in performance measurement of MCO by State agency	Yes	Yes	Yes	Yes
Provide for Incentive Payments that are Tied to HEDIS Performance	Yes	No	Yes	No

* - Individual MCO contracts are unavailable; model contracts/agreements were reviewed.

Kentucky	Maryland*	Minnesota	Nebraska	New Mexico	Ohio	Oregon	Rhode Island	Tennessee	Washington*
No	No	No	Yes	No	No	No	No	Yes	No
N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A	No	N/A
N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A	No	N/A
Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	N/A	Yes
Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	N/A	Yes
No	No	No	No	Yes	Yes	No	No	No	No
Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
No	No	No	No	No	No	Yes	Yes	Yes	No
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
No	Yes	No	No	No	Yes	No	Yes	Yes	No

A Review of Managed Care Organization Contracts
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Staff

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