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NEWS RELEASE

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FOR RELEASE July 27, 2020

Auditor of State Rob Sand today released a report on a survey of healthcare providers regarding the manner in which Medicaid is administered. The Medicaid program in Iowa is managed by the Iowa Department of Human Services (DHS). Medicaid pays for health care services for individuals with limited income and resources who meet Medicaid eligibility requirements. Prior to 2016, authorized providers billed DHS for services to Medicaid members and were paid by DHS on a fee-for-service basis. On August 17, 2015, DHS issued a notice of intent to award contracts to four Managed Care Organizations (MCOs) to administer the program. DHS transitioned most Iowa Medicaid members from a fee-for service to a Medicaid managed care system called IA Health Link on April 1, 2016. As of July 1, 2019, there are 2 MCOs administering the program. Governor Terry Branstad stated that Medicaid privatization would save money, improve access, and improve quality of care.

Sand reported 2,592 of 11,801 providers which were eligible to provide Medicaid services were surveyed, of which 813 who provided services under both models responded. Thus, it can said with 95% certainty that if the entire population of Medicaid providers had been surveyed, the answers would fall between 3 percentage points lower and 3 percentage points higher than the answers listed in the report. For example, if 60% of those surveyed took a particular position, then 57-63% would take that position with a survey of every single provider.

Sand asked providers to compare services, timeliness of payments, and any additional costs between the fee-for-service (FFS) model and MCO model. Providers were asked about benefits and advantages of the MCO model as compared to FFS. Providers were also asked about financial information, including outstanding balances of MCO payments, debt entered into as a result of MCO delaying payments, and if there were additional staffing and administrative costs incurred as a result of implementing the MCO model. The providers' responses to survey questions are included in the report. Some of the responses received from providers include:

- 6.1% of respondents felt privatization had been beneficial to quality of care; 51.5% felt it had been negative, as noted in **Table 25** of the report.
- 9.9% of respondents felt privatization had been beneficial to access to care; 54.0% felt it had been negative, as noted in **Table 26** of the report.
- 26.5% of respondents agree are satisfied or extremely satisfied with MCOs' impact on providers' ability to provide services to Medicaid patients; 41.1% are dissatisfied or extremely dissatisfied, as noted in **Table 3** of the report.

- When presented with 3 positive impacts privatization may have had on their business, over 2/3rds of respondents instead chose "other" and then stated no positive impacts or stated a negative impact, as noted in **Table 5** of the report.
- As shown in **Table 11** of the report, within the substantial majority of providers that believe policies, procedures, and guidelines have become more strict under MCOs, they believe by a 5-to-1 margin that the restrictions are inappropriate. Just 2% of all respondents believed new restrictions were appropriate.

In addition, Sand reported all the hospitals in Iowa publicly listed by the Iowa Hospital Association were sent a survey. Hospitals across Iowa are an integral part of their local healthcare systems. Because of their significant contributions to overall community well-being and status as often the sole provider of emergency services, they are a critical component of communities. As such, any impacts upon them from the switch to a managed care system for Medicaid patients should be more closely monitored. Some of the responses received from the hospitals include:

- Within the vast majority of hospitals that believe policies, procedures, and guidelines have become more strict under MCOs, they believe by a 12-to-1 margin that the restrictions are inappropriate.
- 82.9% of the hospitals responding reported they were either extremely dissatisfied or dissatisfied with MCOs' timely and accurate payment for services as illustrated in **Table 4** of the report.
- 91.4% of the hospitals responded settling claims is a more complex process through MCOs as illustrated in **Table 7** of the report.

Based on the responses received to the survey, hospitals have continued to provide services, but the MCOs have increased the frequency of denied services. As a result, the hospitals bear the cost of the services which they have continued to provide.

In addition, Sand reported providers responded there is not a standard model for authorizations, claims coding, claims processing, and timeliness. Each MCO sets its own standards in terms of what is / is not authorized, the services that require prior authorizations, claims coding, how claims are to be submitted for payment, and the deadlines for various scenarios associated with reporting services provided and ultimately receiving payment for those services. Sand recommended DHS/IME consider the viability of establishing a single set of policies, procedures, and requirements to be implement by all current and future MCOs with which contracts are established. The efficiencies to be gained can be realized by all providers and DHS during their monitoring and 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 spreadsheet containing all answers to survey questions which could not jeopardize respondents' anonymity is available on the Auditor of State's web site at https://auditor.iowa.gov/media/cms/Medicaid_Surveys_2AD0A7A2CA174.xlsx .

# # #

REPORT ON A SURVEY OF HEALTHCARE PROVIDERS COMPARING MEDICAID'S MANAGED CARE MODEL TO THE FEE-FOR-SERVICE MODEL

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 surveyed Iowa healthcare providers who received payment for services from the Department of Human Services (DHS) through contracted Managed Care Organizations (MCOs) for services provided to Iowa Medicaid members/enrollees. In addition, we compiled survey responses based on provider experiences regarding services and administration under the fee-for-service (FFS) model compared to the MCO models for Medicaid.

With the assistance of staff from DHS and the Iowa Medicaid Enterprise (IME), we obtained a population of Medicaid providers for the period April 1, 2016, through July 31, 2019. Using this population, we randomly selected providers to survey. In conducting our survey, we inquired about the following:

(1) If the providers surveyed administered Medicaid services under the FFS model and the MCOs model.

(2) Which MCOs the providers were affiliated with or had experience with.

(3) Experience providers had with the MCOs and their ability to provide services to patients, as well as the timeliness and accuracy of payments to the providers by the MCOs. The survey also addressed provider experience regarding the timeliness of payments for services and settling claims under MCOs compared to FFS.

(4) Provider overall experience with moving from the FFS model to the MCO model.

(5) Financial impact switching from the FFS model to the MCO model had on providers.

(6) Outstanding MCO payments to providers which are over 90 days.

(7) Provider experience regarding costs associated with staffing and administration, as well as uncollectible fees written off and/or issuance of debt under the MCOs in comparison to FFS.

(8) If providers or their organization added or reduced the number of employees as a result of moving to the MCO model.

(9) Provider experience with Medicaid policies, procedures, or guidelines under the MCOs compared to FFS.

(10) If providers have increased or decreased the number of Medicaid members served as a result of switching to the MCO model and, specifically, providers decreased the number of Medicaid members served as a result of delayed payments from MCOs.

(11) Any changes experienced by providers regarding services allowed or covered by MCOs which were/were not covered under the FFS model and if providers have identified changes in denied services to Medicaid members by MCOs.

(12) Any impacts on the access to and quality of medical care and attention Medicaid recipients received due to the MCO model.

(13) Benefits and disadvantages of the FFS model and the MCO model identified by the providers.

(14) Any concerns identified by providers.

We have compiled the responses received from the providers surveyed and categorized their answers for reporting purposes. The responses are described in detail in the report. A spreadsheet containing all answers to survey questions which could not jeopardize respondents' anonymity is available at https://auditor.iowa.gov/media/cms/Medicaid_Surveys_2AD0A7A2CA174.xlsx .

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 which would have been reported to you.

Rob Sand
Auditor of State

April 20, 2020

Introduction

Medicaid Background

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 the Iowa Department of Human Services (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 (MCO model) 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 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 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% 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 claims submitted by the MCOs and if any errors are identified, the encounter data 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.

Objectives, Scope, and Methodology

Objectives

Our review was conducted to determine:

- How healthcare providers in Iowa have been impacted by the change from the fee-for-service (FFS) model to the MCO model.
- How healthcare providers in Iowa perceive Medicaid members have been impacted by the change from the FFS model to the MCO model.
- If there are areas in which the MCOs can improve to meet the administrative and service needs of healthcare providers and Medicaid members.

Scope and Methodology

To conduct our survey, we:

- Requested and received a list of all providers receiving Medicaid payments through an MCO from DHS/IME for the period April 1, 2016, through April 3, 2019.
- Generated a survey questionnaire to accomplish the objectives.
- Generated from within complete lists of providers for different types of medical care a random selection of providers to complete the survey questionnaire using a random number generator.
- Compiled the responses from the surveyed providers and reviewed and analyzed the information for reporting purposes.

Once survey results were received, the responses were electronically summarized and compiled in a manner that allowed us to determine the portion of the responding providers that answered survey questions in a similar manner. The responses we received were categorized and graphically summarized. However, it should be noted the tables and schedules compiled of the responses do not consistently total 100% because the manner in which the responses were summarized involved rounding. Specifically, in some cases, the total responses for a particular question is displayed in a graph or table as slightly less than or slightly more than 100%. The totals typically ranged from 99.6% to 100.2% as a result of rounding.

Selection of Providers Surveyed

Using a listing provided by DHS/IME, we grouped providers into 11 categories of healthcare. The categories and related descriptions are as follows:

- Chiropractic – included practitioners and practices.
- Health care providers and medical clinics – included physicians, physician assistants, nurse practitioners, and similar fields providing services in a clinical, non-hospital setting.
- Home health and hospice providers.
- Hospitals.
- Long-term care and dependent care – included nursing facilities and providers caring for dependent persons.
- Medical equipment providers - included durable medical equipment, diabetic supplies, orthotics, prosthetics, and similar equipment.
- Mental health and substance abuse – included practitioners, counselors, and clinics/providers.

- Optometry – included practitioners and optometry practices.
- Physical, occupational, and speech therapy – included practitioners and therapy practices.
- Transportation providers - included emergency and non-emergency providers.
- All other – those providers not specifically identified to the previously listed categories.

Our population did not include the following groups:

- Providers outside the state of Iowa.
- Pharmacies, which are governed by more specific payment rules and interact directly with Prescription Benefit Managers (PBMs), which we are auditing separately.
- Atypical providers identified by DHS. DHS' identification of atypical providers is based on the definition established by CMS which states atypical providers are providers that do not provide health care. Taxi services, home and vehicle modifications, consumer directed attendant care (CDAC) providers, and respite services are examples of atypical services.

These parameters narrowed the population to 14,085 providers; however, during our review of the data, we identified duplication of providers. After removing the duplications, our population was narrowed to 11,801 providers from which to select providers to survey. However, during our review, we determined the 11,801 of providers in the population was not an exact number of providers. We determined it is common for providers to practice at more than one location. As a result, each practice location would be included as a separate provider in the 11,801 providers identified. In addition, acquisitions and mergers of providers can cause the same providers to be in the population under both pre- and post- acquisition names.

With the 11,801 providers grouped into the 11 categories listed above, we randomly selected 2,500 providers across the 11 categories in proportion to the total providers in each category. For example, of the 11,801 providers in the population, 1,479 were identified as Chiropractic providers which represents 12.53% of the population. This same percentage was applied to the 2,500 total providers in the survey resulting in 313 chiropractic providers randomly selected as part of the survey process. However, we decided to survey all of the hospitals publicly listed by the Iowa Hospital Association because of their significant contributions to overall community well-being and status as often the sole provider of emergency services. As a result, the survey size was increased to 2,592 for the inclusion of all Iowa hospitals.

On November 4, 2019, we provided instructions and a link for completing the survey online to the 2,592 providers selected. A second letter was sent on November 14, 2019 reminding providers to complete the survey. The online survey was active through December 2, 2019 at which point, electronic access to the survey was terminated and it was no longer available for completion.

At the ending of the survey period, we had received 877 responses from the 2,592 providers surveyed, for a response rate of 33.8%. A total of 1,487 providers did not respond for a non-response rate of 57.4%. The remaining providers either declined to respond to the survey (90 providers, or 3.5%), or the mailings were returned by the U.S. Postal Service as undeliverable (138 providers, or 5.3%). **Table 1** summarizes the survey participation by provider category for the 877 providers responding to the questionnaire.

Table 1

Provider Category	Number of Providers Surveyed	Number of Providers Responded	Response Rate (%)
Chiropractic	313	170	54.3%
Health Care Providers/Medical Clinics	992	168	16.9
Home Health/Hospice	68	31	45.6
Hospitals	120	71	59.2
Long-term Care/Dependent Care	191	105	55.0
Medical Equipment/Supplies	62	23	37.1
Mental Health/Substance Abuse	348	134	38.5
Optometry	226	77	34.1
Physical/Occupational/Speech Therapy	130	33	25.4
Transportation	81	36	44.4
All Other	61	29	47.5
Totals	2,592	877	33.8

Survey Subject Matter

The survey included several questions which asked the providers to compare services, timeliness of payments, and any additional costs between the FFS model and MCO model. In addition, we asked providers about financial information, including, but not limited to, any outstanding balances of MCO payments, any debt entered into as a result of MCO delaying payments, and if there were any additional costs, such as staffing and administration, due to implementation of the MCO model. The providers' responses to survey questions are discussed in more detail in the following paragraphs.

Provider Participation in Fee-for-Service and Managed Care Models

At the beginning of the survey, providers were asked two questions regarding their participation in the previously utilized FFS model administered by the State, and the currently administered MCO model. The questions required a "yes" or "no" response to: (1) did you previously provide services to Medicaid clients under the FFS model, and (2) are you currently providing services to Medicaid clients through a MCO?

Of the 877 overall responding providers, 813 (92.7%) answered they did provide services under both models. The remaining 64 (7.3%) answered they provided services only under one of the models, or neither model at all. Because the survey was designed to collect information from each provider in order to compare FFS and MCO models, the 64 providers who did not provide services under both models were eliminated from the analysis. The 813 providers summarized above were used as the supporting data for analyzing and reporting the survey results. For the Medicaid provider population as a whole, the response rate provides a margin of error of 3% at the 95% confidence interval, meaning that if the entire population of Medicaid providers had been surveyed, we can say with 95% certainty that the answers would fall between 3 percentage points lower and 3 percentage points higher than the number listed here.

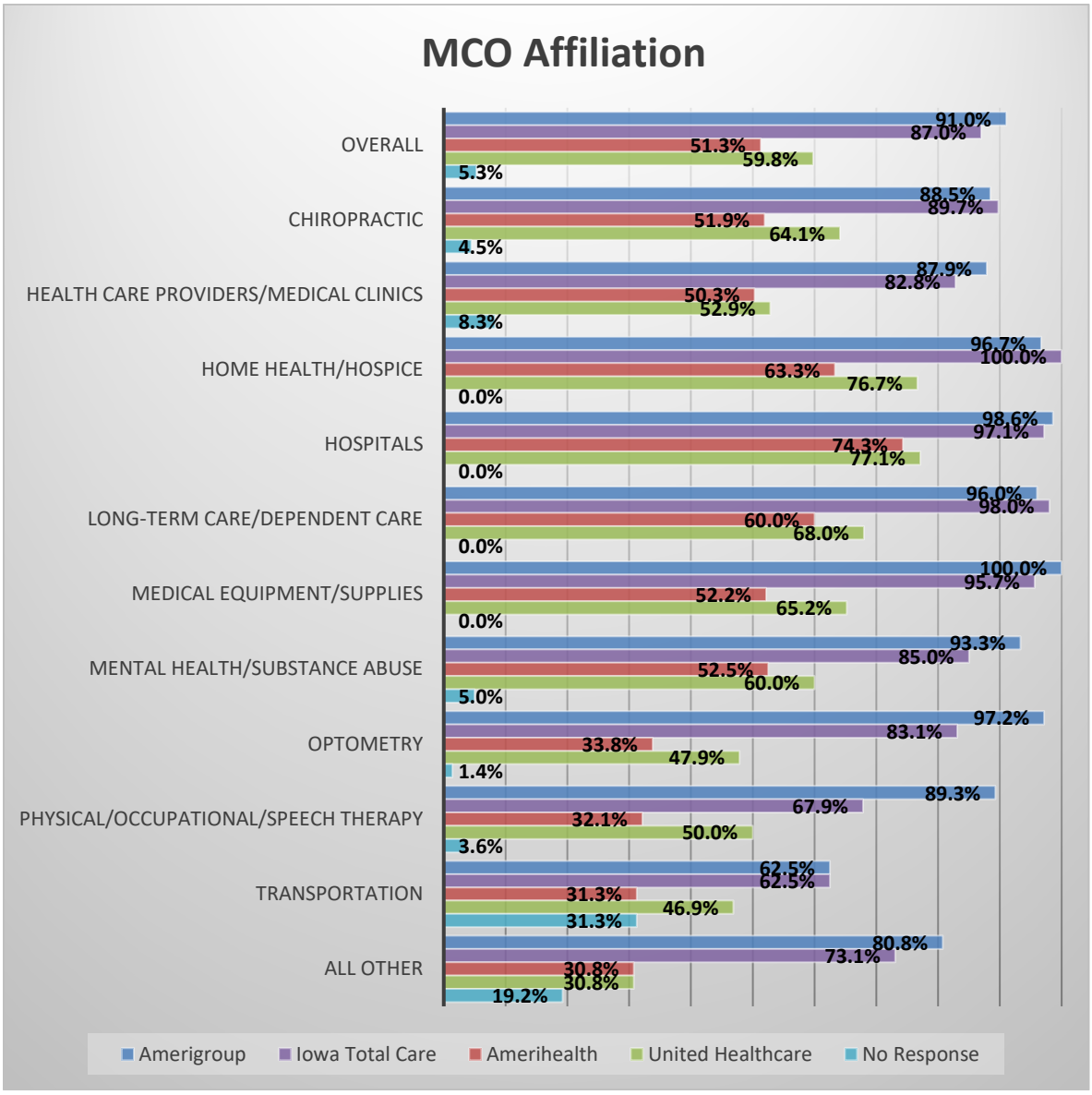
Provider Affiliation with Managed Care Organizations (MCOs)

There were 4 MCOs which have been or are currently under contract with DHS since the inception of managed care in Iowa on April 1, 2016. The period of our review includes the period from April 1, 2016 through July 31, 2019. The 4 MCOs that have provided services during this time include Amerigroup Iowa, AmeriHealth Caritas Iowa, UnitedHealthcare Plan of the River Valley (UHC), and Iowa Total Care (ITC). The providers surveyed were asked to identify all the MCOs with which they were affiliated for purposes of the Medicaid program.

In completing the survey, providers could select as many MCOs from the list as necessary in order to report all affiliated entities. Overall, 91.0% of the providers listed Amerigroup Iowa, one of Iowa's two currently contracted MCOs, as an affiliated MCO. The other currently contracted MCO, Iowa Total Care, was listed by 87.0% of the overall respondents as an affiliated MCO.

The two MCOs no longer under contract in Iowa, AmeriHealth Caritas Iowa and UnitedHealthcare Plan of the River Valley, were affiliated with 51.3% and 59.8% of the providers, respectively. Overall, 5.3% of the providers did not provide a response when asked to list their affiliated MCOs. The MCO affiliation rate of the responding providers for each category are summarized in **Table 2**.

Table 2

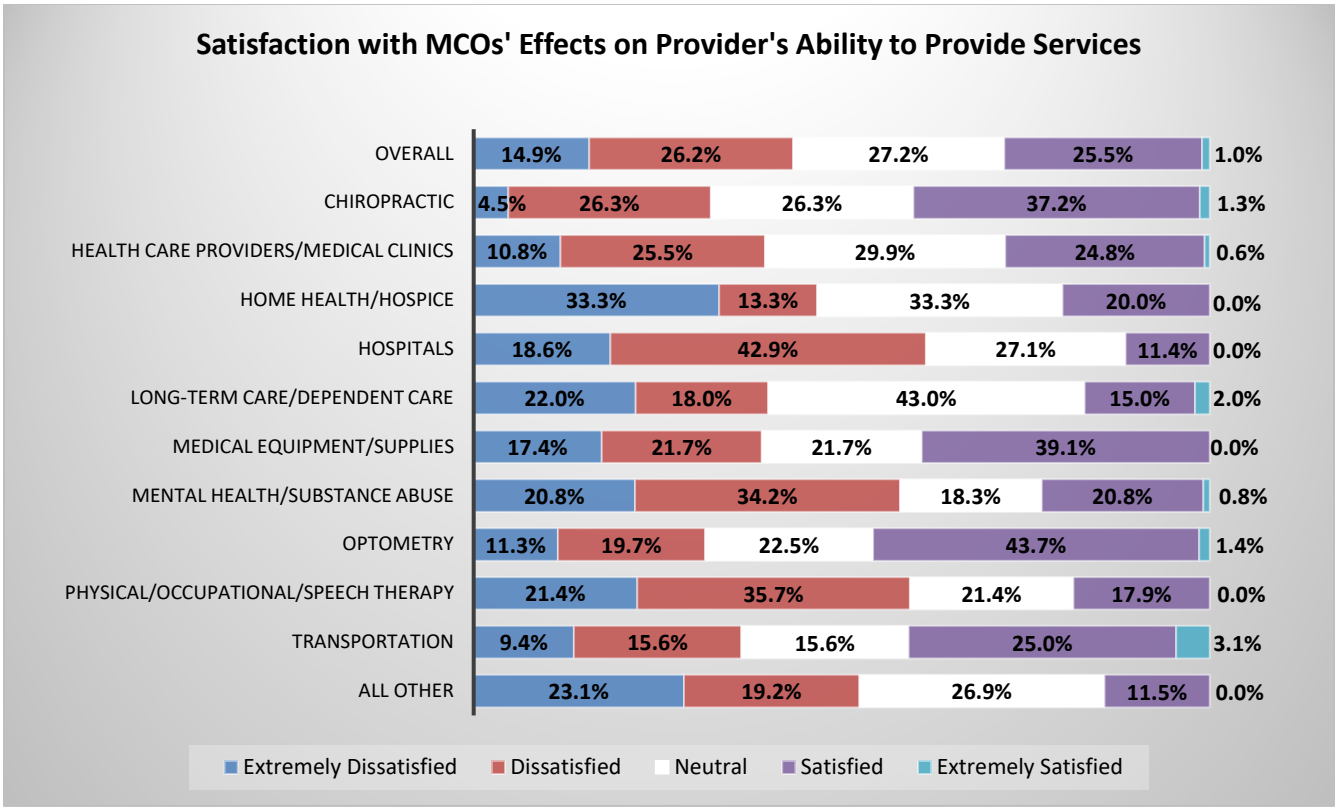


Provider Satisfaction with the Manager Care Organizations (MCOs)

The providers surveyed were asked two questions regarding their satisfaction with the MCOs provision of services to Medicaid patients. Specifically, the providers were asked: (1) how satisfied has your entity been with MCOs in terms of your ability to provide services to Medicaid patients, and (2) how satisfied have you been with MCOs in terms of timely and accurate payment for services provided to Medicaid patients? The providers were given five options in which to express an answer: extremely satisfied, satisfied, neutral, dissatisfied, and extremely dissatisfied.

According to the data, 41.1% of the providers overall were either dissatisfied or extremely dissatisfied with the MCOs when it comes to the providers' ability to provide services to Medicaid patients. Only 26.4% of providers overall were satisfied or extremely satisfied, 27.2% of providers were neutral on this topic, and 5.3% did not respond to this survey question. The breakdown of MCO satisfaction by provider category are summarized in **Table 3**.

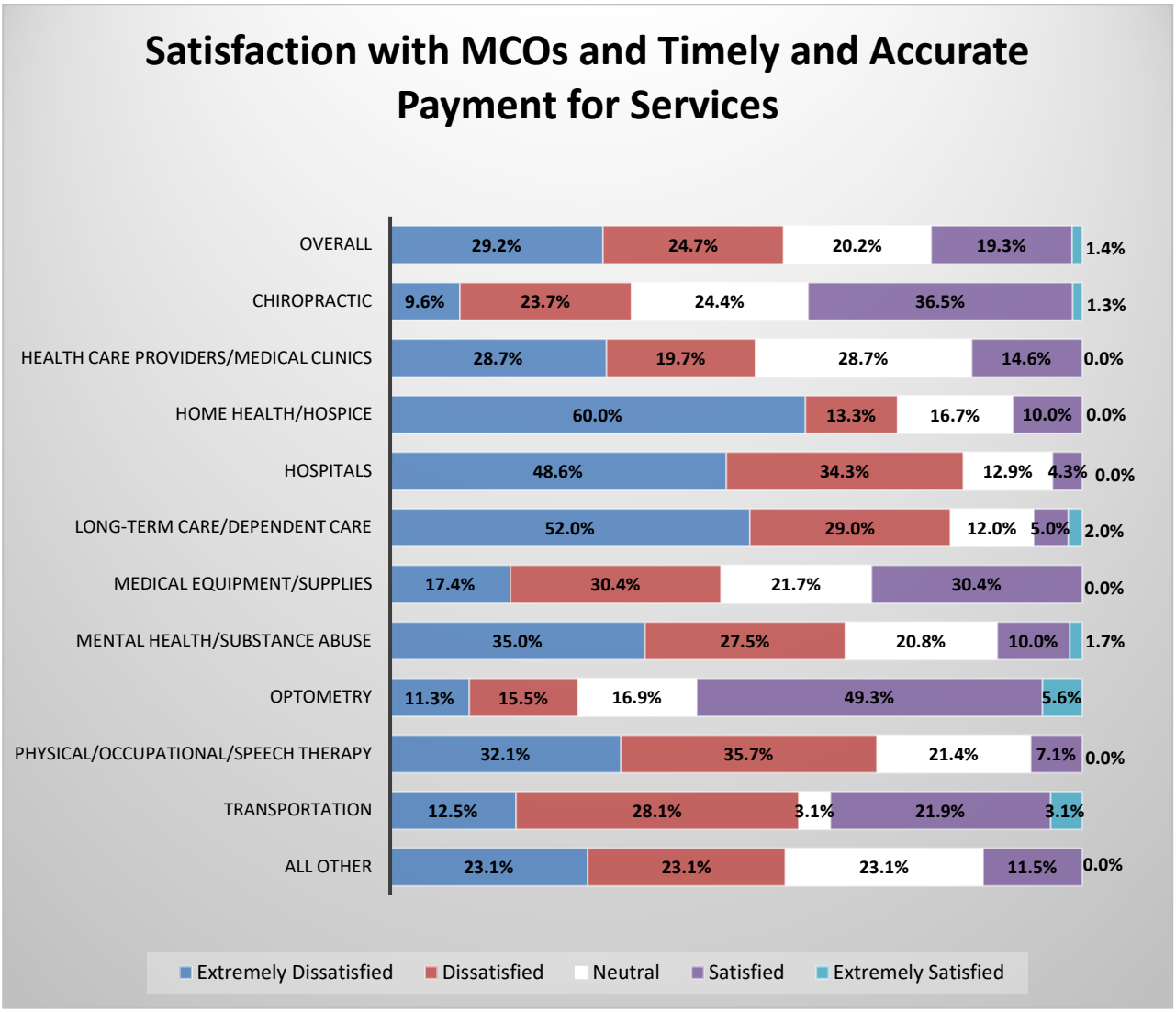
Table 3



As illustrated by the **Table**, the highest dissatisfaction or extreme dissatisfaction was reported by the hospital providers at 61.4%. However, the highest level of satisfaction or extreme satisfaction was reported by optometry providers at 45.1%.

In addition to analyzing satisfaction with MCOs and providers ability to provide services, we analyzed the providers satisfaction with the MCOs regarding their timely and accurate payment for services provided to Medicaid patients. Overall, 53.9% of the providers were either dissatisfied or extremely dissatisfied with the MCOs and only 20.7% of providers were satisfied or extremely satisfied. However, 20.2% of providers were neutral on this topic and 5.3% did not respond to this survey question. The breakdown of MCO satisfaction level by provider category is summarized in **Table 4**.

Table 4



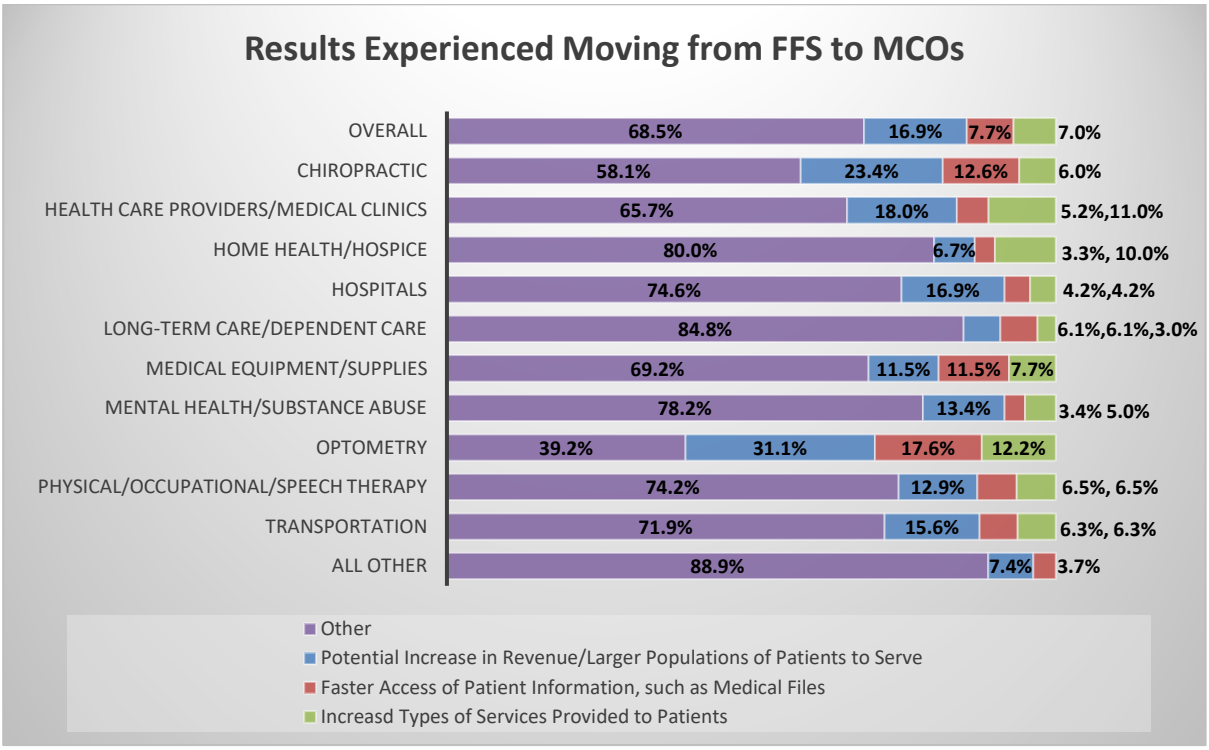
As illustrated by the **Table**, the highest dissatisfaction or extreme dissatisfaction was reported by hospital providers at 82.9% while the highest level of satisfaction or extreme satisfaction was reported by optometry providers at 54.9%.

Results Experienced Moving from FFS Model to MCO Model

The providers surveyed were asked to identify from four choices any results they experienced as a result of moving from the FFS model to MCO model for Medicaid services. The four choices for selection to describe the provider experiences were: (1) potential increase in revenue/larger populations of patients to serve, (2) faster access of patient information such as medical files, (3) increased types of services provided to patients, and (4) other (please specify). Providers could select multiple answers, and many responded by selecting more than one choice.

When provided with these four choices, 68.5% of the surveyed providers selected "other." The response "potential increase in revenue/larger populations of patients to serve" was 16.9%. The response "faster access of patient information, such as medical files" was chosen at a rate of 7.7% and the response "increased types of services provided to patients" was at a rate of 7.0%. The breakdown of provider experience moving from the FFS model to the MCO model is summarized for each provider category in **Table 5**.

Table 5



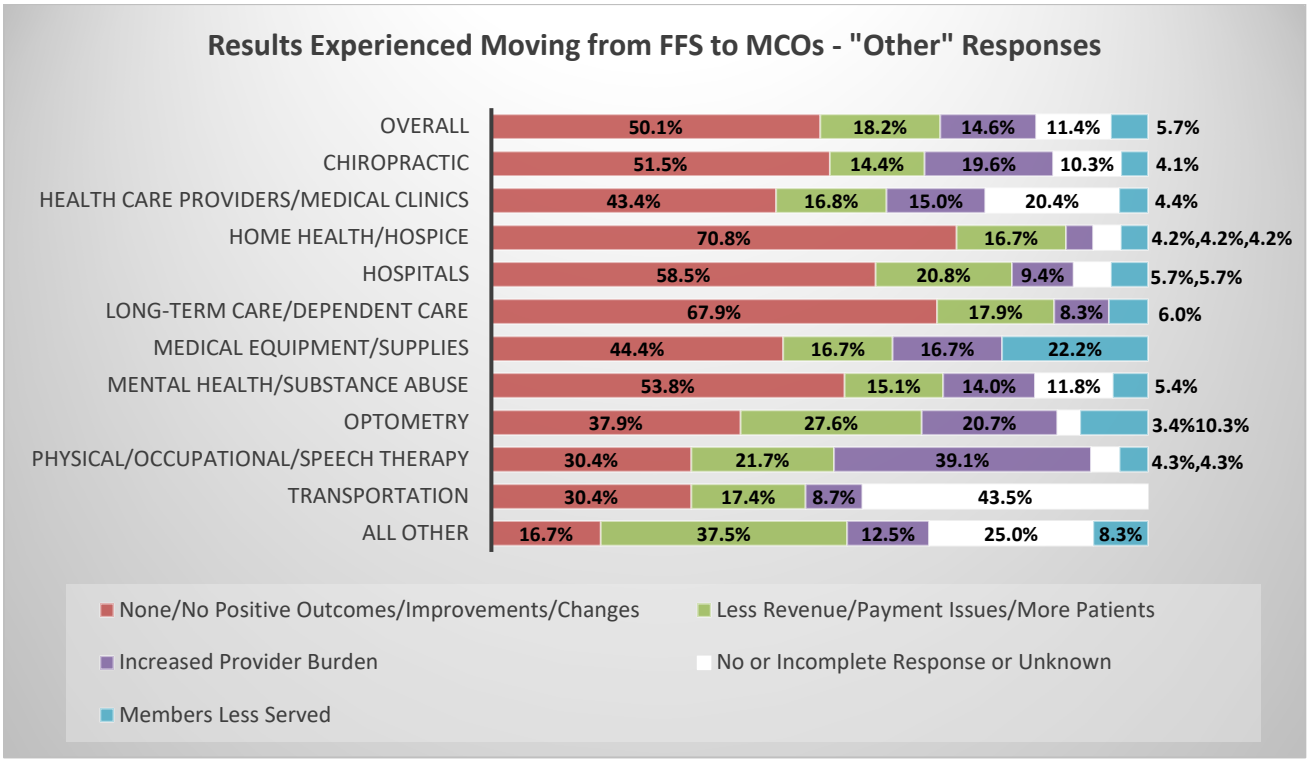
As illustrated by the **Table**, the most common answer was "other." We reviewed the specific notations identified with the "other" responses to determine the nature of the feedback and the results of the provider experiences with Medicaid moving from FFS to the MCOs. During our review, we determined the feedback could be classified into the five following "general" categories with many of the providers' responses containing feedback which applied to several of the general categories. As a result, we included the provider responses under as many of the general categories as applicable.

1. None or No Positive Outcomes/Improvements/Changes – Of all "other" responses, 50.1% of the providers believed none of the provided choices were applicable, or no positive outcomes, improvements, or changes were identifiable by the providers in their experience moving from FFS to the MCOs.
2. Less Revenue/Payment Issues/More Patients – Of all "other" responses, 18.2% of the providers reported receiving less reimbursement/revenue, incurring payment issues such as denied and delayed payments, or experiencing less reimbursement yet seeing more Medicaid patients in their experience moving from FFS to the MCOs.
3. Increased Provider Burden or Costs – Of all "other" responses, 14.6% of the providers responses included more administrative costs, time, or difficulties experienced in moving from fee-for-services to the MCOs.
4. No or Incomplete Response or Unknown/Unsure – Of all "other" responses, 11.4% of the providers did not provide a response, the response was incomplete and could not be specifically determined, or the provider did not believe they were able to compare FFS to the MCOs
5. People or Members Served Less Frequently – Of all "other" responses, 5.7% of the providers believed Medicaid patients/members had been served less frequently or underserved due to the move from FFS to the MCOs.

After our analysis and review of the "other" response information, we determined 50.1% of the providers did not experience positive outcomes or see improvements or changes with the move from

FFS to the MCOs. In addition, 18.2% of the providers experienced less revenue, incurred payment issues, and/or experienced providing services to more patients in the process. The remaining providers experienced an increased provider burden or costs when move from FFS to the MCOs (14.6%), did not respond or respond completely (11.4%), or believed Medicaid members were less served or underserved (5.7%). **Table 6** summarizes the experiences for the "other" responses by each provider category.

Table 6



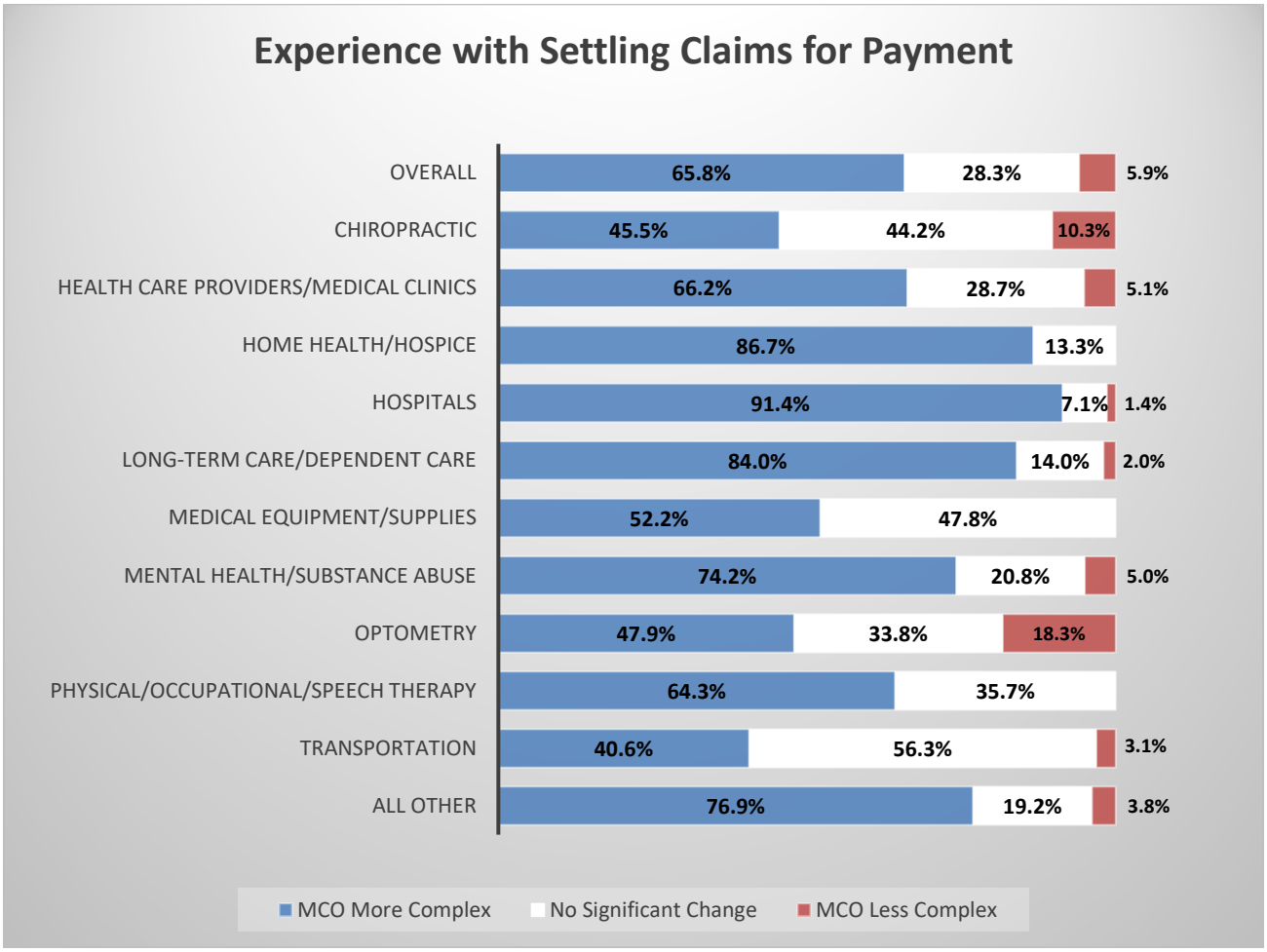
Settling Claims and Payment Timeliness

The providers surveyed were asked to compare the MCO model to the FFS model regarding two areas affecting their reimbursement for services rendered to Medicaid members: (1) the settling of claims and (2) the timely receipt of payment. Specifically, the providers were asked to describe their experience in settling claims for payment using the three choices provided:

1. Settling claims is more complex and takes longer with MCOs than under the FFS model;
2. Settling claims is less complex and takes less time with MCOs than under the FFS model; or
3. No significant change.

According to analysis of the provider responses, 65.8% of the providers reported settling claims for payment was more complex and took longer with the MCOs than under the FFS model. In addition, 28.3% of the providers believed there was no significant change in settling claims when comparing the MCOs to the FFS model and the remaining 5.9% of providers felt the MCOs were less complex and faster in settling claims for payment than the prior FFS model. The breakdown of the provider feedback regarding their experience in settling claims is listed by provider category in **Table 7**.

Table 7



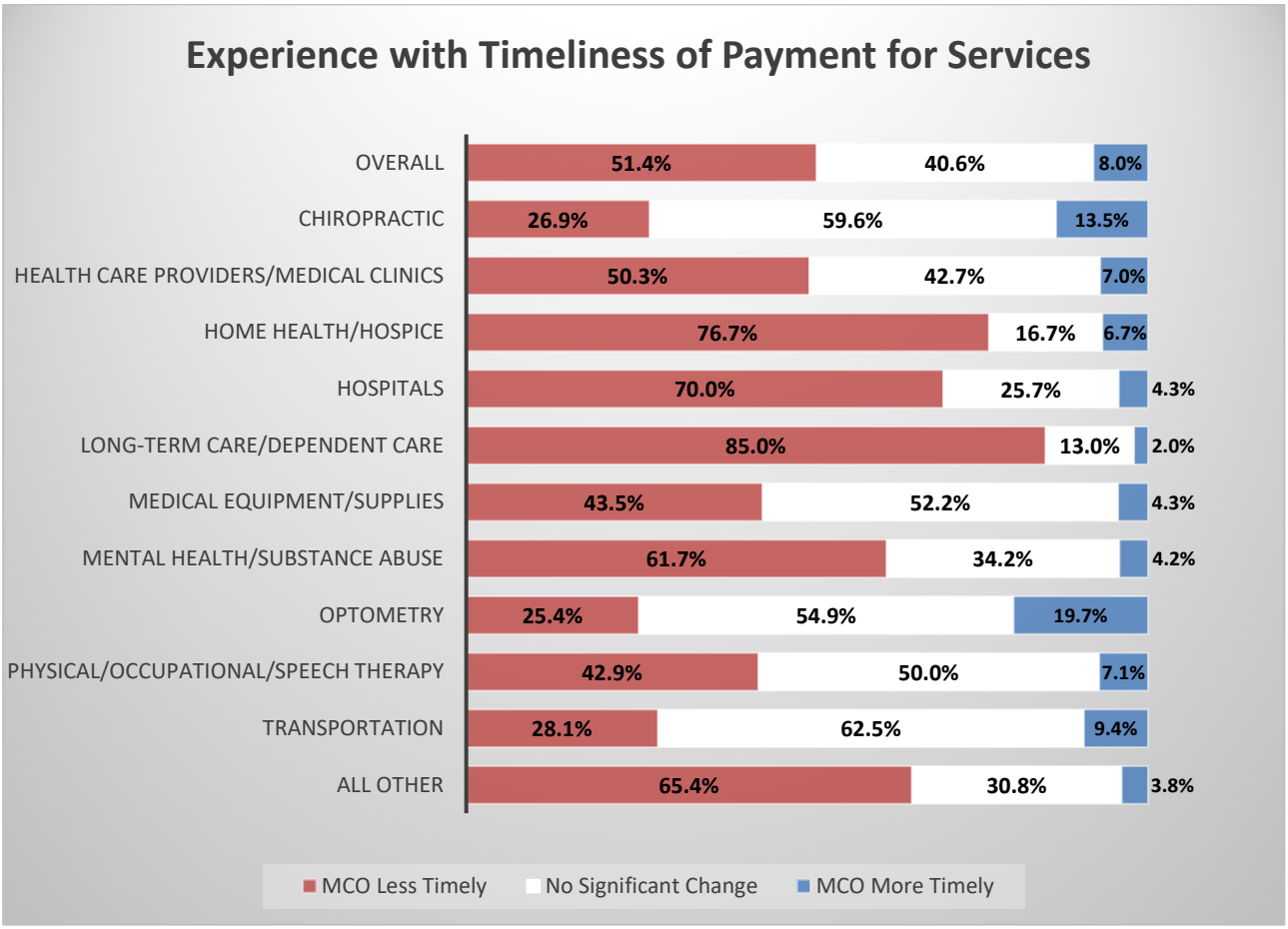
As illustrated by the **Table**, the majority of the provider categories responding stated they believe the MCOs are more complex and time consuming when it comes to settling claims for payment than the FFS model. However, over half of the transportation providers did not believe there was a change in settling claims for payment when comparing the MCO model to the FFS model.

In addition, to obtain providers' experience with the timeliness of payment, the providers were asked to describe their experience with the timeliness of payments for services using the three choices provided:

1. Payments were received in a more timely manner from MCOs than under the FFS model;
2. Payments were received in a less timely manner from MCOs than under the FFS model; and
3. No significant change.

During our review of the provider data, 51.4% of the providers felt they received their payments for Medicaid services in a less timely manner with the MCOs than under the prior FFS model. However, 40.6% of the providers believed there was no significant change in the timeliness of payments when comparing the MCOs to the FFS model. The remaining 8.0% of providers felt the MCOs provided payments more promptly for services than the prior FFS model. The summary of the provider feedback regarding their experience with timely payments is listed by provider category in **Table 8**.

Table 8



As illustrated by the **Table**, 6 of the categories reported at least half of the providers believed they received their payments for Medicaid services in a less timely manner with the MCOs than under the prior FFS model.

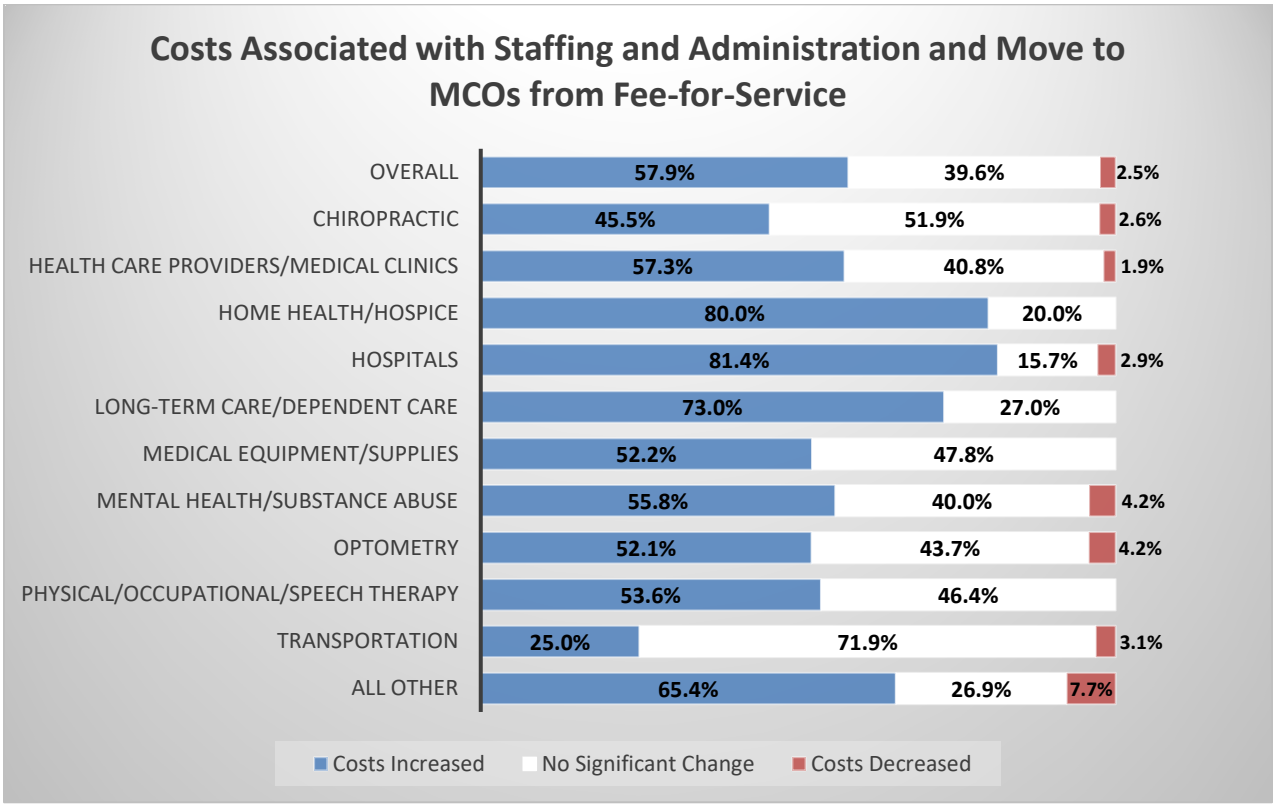
Costs Associated with Staffing and Administration, Uncollectible Fees Written-Off, and Debt

The providers surveyed were asked to compare the MCO model to the FFS model regarding two areas impacting their operating costs: the costs associated with staffing and administration, and the uncollectible fees written off and/or issuance of debt. In order to determine costs associated with staffing and administration, providers were asked to describe costs associated with staffing and administration based on their experience using the three choices provided:

1. Costs have increased as a result of moving to MCOs from FFS;
2. Costs have decreased as a result of moving to MCOs from FFS; or
3. No significant change as a result of moving to MCOs.

According to provider responses, 57.9% of the providers reported their cost associated with staffing and administration increased as a result of the move to the MCOs from the FFS model. In addition, 39.6% of the providers believed there was no significant change in such costs when comparing the move to MCOs from the FFS model and the remaining 2.5% of providers reported their costs associated with staffing and administration decreased as a result of the move to the MCOs from the FFS model. The breakdown of the provider feedback regarding their experience with costs associated with staffing and administration is listed by provider category in **Table 9**.

Table 9



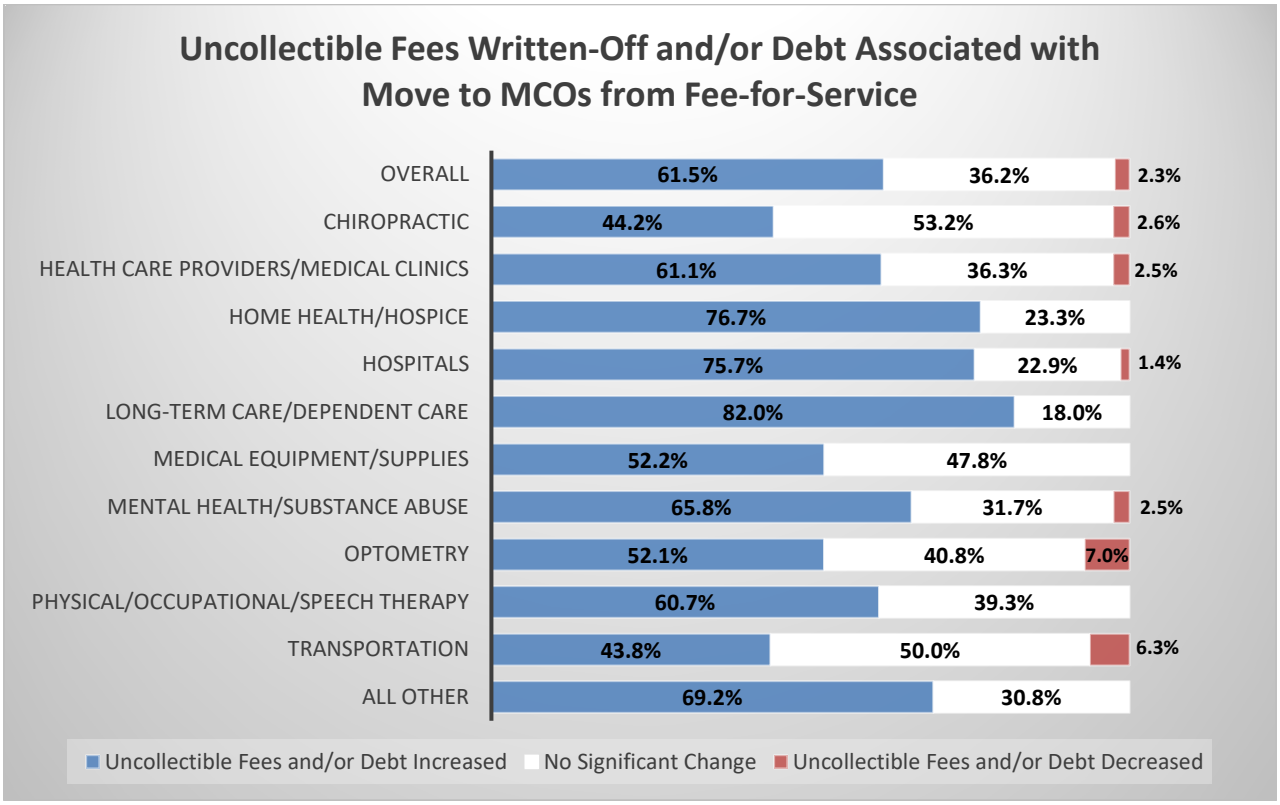
As illustrated by the **Table**, more than 50% of the respondents within 9 of the 11 provider categories experienced increased costs associated with staffing and administration as a result of moving to the MCOs from the FFS model. However, over 50% of the respondents in the remaining 2 provider categories reported there was no significant change with costs associated for staffing and administration.

We also surveyed providers' experience with uncollectible fees and/or issuance of debt associated with the move to MCOs from the FFS model. The providers were asked to describe the amount of uncollectible fees written off and/or issuance of debt based on their experience using the three choices provided:

1. Uncollectible fees written off and/or issuance of debt has increased as a result of moving to MCOs from FFS;
2. Uncollectible fees written off and/or issuance of debt has decreased as a result of moving to MCOs from FFS; and
3. No significant change.

The providers responses show 61.5% reported their uncollectible fees written off and/or issuance of debt increased as a result of the move to MCOs from the FFS model. In addition, 36.2% of the providers believed there was no significant change in such uncollectible fees written off and/or issuance debt when comparing the move to MCOs from the FFS model. The remaining 2.3% of providers reported their uncollectible fees written off and/or issuance of debt decreased as a result of the move to the MCOs from the FFS model. The breakdown of the provider feedback regarding their experience with uncollectible fees written off and/or the issuance of debt is listed by provider category in **Table 10**.

Table 10



As illustrated by the **Table**, for 9 of the 11 provider categories at least half of the providers reported they experienced an increase in uncollectible fees written off and/or issuance of debt as a result of moving to the MCOs from the FFS model.

Provider Experience with Medicaid Policies, Procedures, and Guidelines with Change from FFS to MCOs

The providers surveyed were asked to compare the MCO model to the FFS model regarding the application of Medicaid policies, procedures, and guidelines. More specifically, the providers were asked to describe the Medicaid policies, procedures, and guidelines in regards to their experience under the change from FFS to the MCOs using five possible responses:

1. Policies, procedures, or guidelines have become appropriately stricter under MCOs than FFS;
2. Policies, procedures, or guidelines have become inappropriately stricter under MCOs than FFS;
3. Policies, procedures, or guidelines have become appropriately less strict under MCOs than FFS;
4. Policies, procedures, or guidelines have become inappropriately less strict under MCOs than FFS; or
5. No significant change.

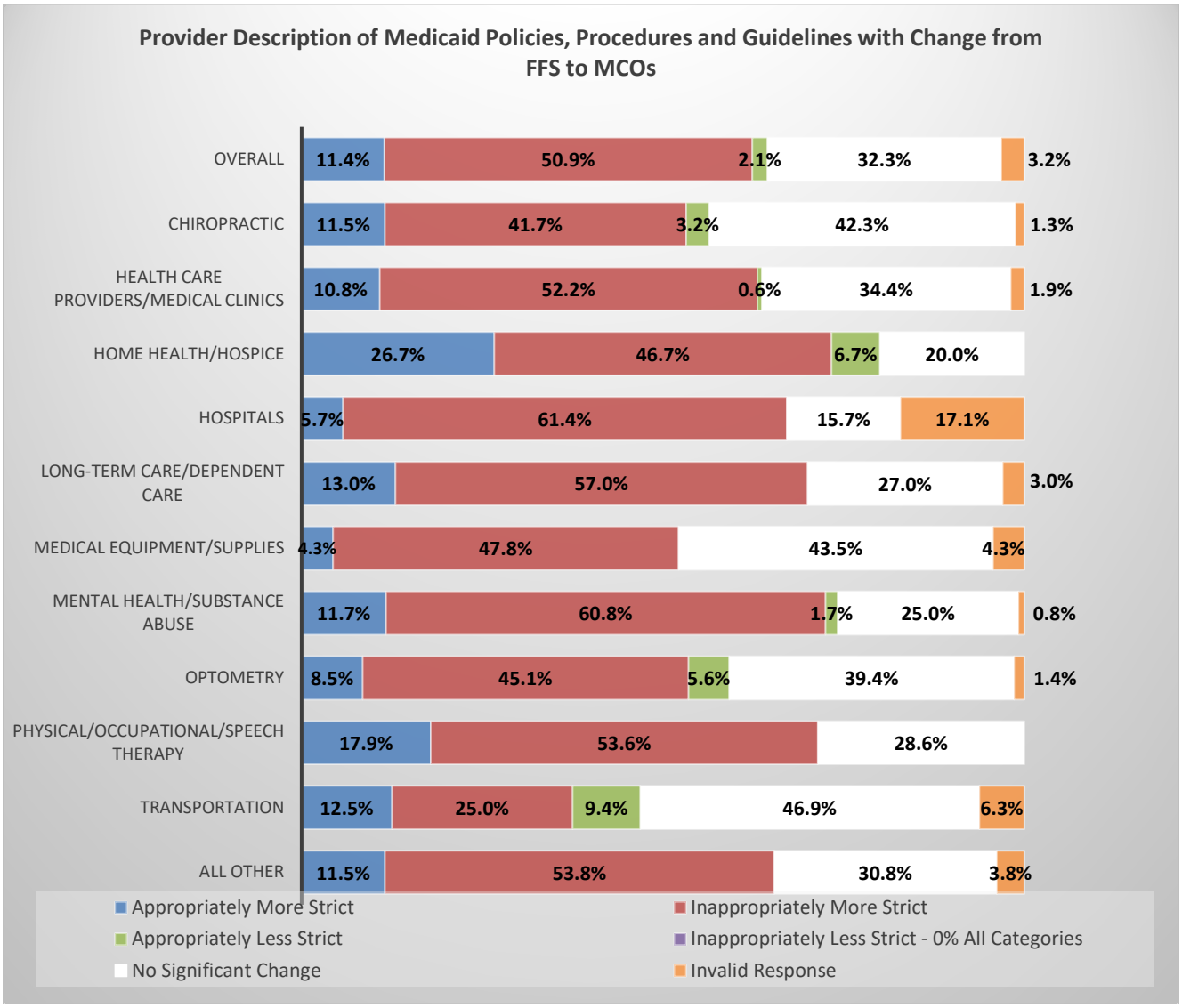
According to analysis of the provider responses, 50.9% of the providers described Medicaid policies, procedures, and guidelines as inappropriately stricter as a result of the change from FFS to the MCOs. However, 32.3% of the providers believed there was no significant change with Medicaid policies, procedures, and guidelines as a result of the move from FFS to the MCOs. The remaining 11.4% of the providers reported the Medicaid policies, procedures, and guidelines were

appropriately stricter with the change from FFS to the MCOs and 2.1% felt they were appropriately less strict.

None of the providers believed the Medicaid policies, procedures, and guidelines were appropriately less strict. During our review of provider data, 3.2% of the providers included invalid responses by selecting more than one of the above five responses in the survey, thereby creating conflicting responses. However, as illustrated by **Table 11**, 17.1% of the responding hospitals provided an invalid response. Specifically, 10 of the 70 hospitals that responded included two conflicting responses such as "policies, procedures, or guidelines have become appropriately more strict under MCOs than FFS"; however they also responded "policies, procedures, or guidelines have become inappropriately more strict under MCOs than FFS." In addition, one hospital provided three responses to the question and one hospital described the change as becoming inappropriately more strict and no significant change in the same response. We are unable to determine why the hospitals believed it was appropriate to respond to the question with more than one answer.

The breakdown of the provider feedback regarding their description of the Medicaid policies, procedures, and guidelines as a result of the change from FFS to the MCOs is listed by provider category in **Table 11**.

Table 11



Benefits and Disadvantages of Managed Care Organizations (MCOs)

During the survey, providers were asked under two different survey topics to describe (1) any benefits and (2) any disadvantages they experienced with the MCO model in place for Medicaid in Iowa. We did not supply predetermined responses for the providers to choose from for these questions. Instead, the providers were given the opportunity to openly remark and describe their experiences.

We analyzed the providers' responses regarding the benefits and disadvantages and classified the content of the responses into "general categories." In many instances, the providers' responses included content that applied to several of the general categories. Consequently, we classified the provider responses under as many of the general categories as indicated by the content.

Our review of the responses regarding benefits resulted in identification of the following 19 general categories. However, as illustrated by numbers 5, 6, 10, 11, 13, 15, 17, and 19, many providers listed disadvantages instead of benefits in response to the inquiry.

1. No Benefit or None Identified – Of all responses, 46.10% providers determined there was no benefit, did not identify a benefit, or were unsure of any benefit of the MCO model for Medicaid.
2. More or Better Served Medicaid Population – Of all responses, 11.8% of providers believed the MCOs led to more Medicaid members being served, or members were better served via such improvements as healthcare choice, better coverage, and improved access to services.
3. Claims Processing/Payment Better/Faster – Of all responses, 8.3% of providers believed the claims processing and/or payment mechanisms of the MCOs were generally better or faster than under the FFS model.
4. Better/More Accessible Coverage/Member Information/Website/Customer Service – Of all responses, 7.1% of providers believed MCO coverage and/or member information was better and/or more accessible, or MCO website or customer service was improved over fee-for-service.
5. Increased Administrative Burden or Costs – Of all responses, 4.5% of providers responded they incurred an increase in costs to operate as a healthcare provider, or additional burden such as more time or resources to handle the change to the MCOs.
6. Payment Inaccuracies/Difficulties or Reduction – Of all responses, 4.1% of provider responses included information concerning experienced inaccuracies, difficulties, denials, etc., with payments, or reductions in payments with the change to the MCO model for Medicaid.
7. No or Incomplete Response – Of all responses, 7.3% did not include any information or the response did not contain information sufficient to determine the content.
8. Money Savings/Less Government – Of all responses, 1.5% of provider responded benefits included real or potential savings for the Medicaid program and/or less government involvement in the Medicaid program by utilizing the MCOs.
9. No Change from FFS – Of all responses, 1.5% of the providers responded they did not see a change or difference between FFS and the MCOs.
10. Not Qualified or Unable to Respond – Of all responses, 1.4% of the providers believed they were not qualified or able to respond to this topic.
11. People or Medicaid Members Less Served – Of all responses, 1.1% this category captured responses by providers that believed people or Medicaid members were less served by the MCO model due to such things as confusion brought on by the MCO change, or challenges in receiving services from providers.

12. Positive Feedback Amerigroup – Of all responses, 0.6% provided positive feedback specific to the MCO Amerigroup. For example, a provider characterized Amerigroup's reimbursement as being quick.
13. Negative Feedback Amerigroup – Of all responses, 0.6% of the responses included negative provider feedback specific to the MCO Amerigroup. For example, a provider advised they received payment in 7 days under FFS, but Amerigroup takes 30 days to pay.
14. Positive Feedback AmeriHealth – Of all responses, 1.0% any positive provider feedback specific to the MCO AmeriHealth. For example, a provider related AmeriHealth had the best customer service.
15. Negative Feedback AmeriHealth – Of all responses, 0.2% of the responses included negative provider feedback specific to the MCO AmeriHealth. For example, a provider believed AmeriHealth had not made the process of electronic claims filing easy for the provider.
16. Positive Feedback UnitedHealthcare – Of all responses, 0.3% of the responses included positive provider feedback specific to the MCO UnitedHealthcare. For example, a provider advised they were able to easily work with UnitedHealthcare and the provider was pleased as costs were down and payments faster than previous Medicaid payments.
17. Negative Feedback UnitedHealthcare – Of all responses, 0.5% included negative provider feedback specific to the MCO UnitedHealthcare. For example, a provider believed UnitedHealthcare constantly called the provider to manage their clinical practice.
18. Positive Feedback Iowa Total Care – Of all responses, 0.5% included positive provider feedback specific to the MCO Iowa Total Care. For example, a provider advised Iowa Total Care was very good at customer service.
19. Negative Feedback Iowa Total Care – Of all responses, 1.2% included negative provider feedback specific to the MCO Iowa Total Care. For example, a provider related they have to file more paperwork due to Iowa Total Care's requirement of prior authorizations for routine visits.

Schedule 1 summarizes the benefits reported by the providers in each of the provider categories. As illustrated by the **Schedule**, when given the opportunity to describe the benefits of the MCO model for Medicaid, the most common response by providers (46.1%) was there was no benefit, or no benefit was provided, with the MCO model. The remaining categories of responses by the providers are listed in **Schedule 1**.

In addition to inquiring about MCO benefits, we also inquired about MCO disadvantages. According to responses provided, we classified the responses into the following 16 different categories. However, as illustrated by numbers 9, 12, and 14, many providers listed benefits instead of disadvantages in response to the inquiry.

1. Payment Inaccuracies/Difficulties or Reduction – Of all the responses, 22.5% of the provider responses included information concerning experienced inaccuracies, difficulties, denials, etc., with claims, claim payments, or reductions in payments with the change to the MCO model for Medicaid.
2. Increased Administrative Burden or Costs – Of all the responses, 19.5% of the providers responded they incurred an increase in costs to operate as a healthcare provider, or additional burden such as more time or resources to handle the change to the MCOs.

3. Program/Administration Difficulties – Of all the responses, 13.3% of the providers believed to be negative programmatic or administration changes in Medicaid with the switch from fee-for-service to the MCOs.

4. Prior Authorization Difficulties – Of all the responses, 11.0% of the providers expressed dissatisfaction with the prior authorization requirements or burden these authorizations caused.

5. Communication/Customer Service Difficulties – Of all the responses, 10.8% of the providers respond the communication and/or customer service by the MCOs impacted the providers negatively in carrying out services for Medicaid beneficiaries.

6. People or Medicaid Members Less Served – Of all the responses, 8.3% of the providers believed people or Medicaid members were less served by the MCO model due to such things as confusion brought on by the MCO change, or challenges in receiving services from providers.

7. No or Incomplete Response – Of all the responses, 4.1% included responses with no information provided, or where the response did not contain information sufficient to determine the content.

8. No Disadvantage or None Identified/Unsure or No Change – Of all the responses, 3.2% of the providers believed there was no disadvantage, did not identify a disadvantage, were unsure of any disadvantage, or believed there was no change with the MCO model for Medicaid.

9. Positive Feedback Amerigroup – Of all the responses, 0.2% provided positive feedback specific to the MCO Amerigroup. For example, a provider stated, "they are set up well with Amerigroup and get authorizations and payments consistently and regularly."

10. Negative Feedback Amerigroup – Of all the responses, 2.5% of the responses included negative provider feedback specific to the MCO Amerigroup. For example, a provider stated, "Amerigroup has cut mental health sessions for certain counselor groups to 24 sessions per year which is unacceptable."

11. Negative Feedback AmeriHealth – Of all the responses, 0.3% of the responses included negative provider feedback specific to the MCO AmeriHealth. For example, a provider stated, "they had to fight for over a year and a half to collect monies AmeriHealth owed the provider for services rendered."

12. Positive Feedback UnitedHealthcare – Of all the responses, 0.1% provided positive feedback specific to the MCO UnitedHealthcare. For example, a provider stated, "they are set up well with Amerigroup and get authorizations and payments consistently and regularly."

13. Negative Feedback UnitedHealthcare – Of all the responses, 0.7% of the responses included negative provider feedback specific to the MCO UnitedHealthcare. For example, a provider stated, "they are still fighting for correct reimbursement from UnitedHealthcare who has left the market which makes colleting appropriate payments extremely difficult if not impossible."

14. Positive Feedback Iowa Total Care – Of all the responses, 0.1% provided positive feedback specific to the MCO Iowa Total Care. For example, in comparison to the other MCOs, a provider stated, "Iowa Total Care has been going well for the provider."

15. Negative Feedback Iowa Total Care – Of all the responses, 3.5% of the responses included negative provider feedback specific to the MCO Iowa Total Care. For example, a provider stated, "Iowa Total Care denies covered services and when they do pay, the amount is usually incorrect."

Schedule 2 summarizes the disadvantages reported by the providers in each of the provider categories. As illustrated by the **Schedule**, the most common disadvantage of the MCOs according

to the providers surveyed was the payment inaccuracies/difficulties or reduction (22.5%). In addition, the **Schedule** shows other top disadvantages experienced by the providers included increased administrative burden or costs (19.5%), program/administration difficulties (13.3%), and prior authorization difficulties (11.0%). The remaining categories of responses by the providers are listed in **Schedule 2**.

Benefits and Disadvantages of Fee-for-Service (FFS) Model

Similar to the MCO model for Medicaid, the surveyed providers were also asked to describe any, (1) benefits, and (2) disadvantages, they experienced with the FFS model in place prior to Iowa's change to the MCOs. Rather than supply responses for the providers to choose from, the providers were given the opportunity to openly remark and describe their experiences.

We analyzed the content of the providers' responses regarding the benefits and disadvantages and classified them into "general categories." In many instances, the provider responses included content that applied to several of the general categories. Consequently, we classified the provider responses under as many of the general categories as indicated by the content.

During our review of FFS benefits, we identified the following 11 general categories in which the provider responses could be classified.

1. Better Program/Administration – Of all the responses, 30.8% of the providers believed FFS was a better program model for Medicaid and/or the State's administration of services under FFS was better overall rather than it currently is under the MCOs.
2. Claims Processing/Payment Better – Of all the responses, 23.4% of the providers believed the claims processing and/or payment mechanisms under FFS were generally better.
3. More or Better Served Medicaid Population – Of all the responses, 8.7% of the providers believed FFS resulted in more Medicaid members being served, or members were better served because healthcare choices, coverage, and access to services were better under FFS than then currently are under MCOs.
4. No Benefit or None Identified or Unsure – Of all the responses, 8.7% of the providers determined there was no benefit, did not identify a benefit, or were unsure of any benefit of the FFS model for Medicaid.
5. Fewer Administrative Burdens/Costs – Of all the responses, 8.1% of the providers reported they incurred fewer costs, or decreased burden such as less time and/or resources to operate as a healthcare provider under FFS.
6. No or Incomplete Response – Of all the responses, 6.8% of the providers did not provide any information, or where the response did not contain information sufficient to determine the content.
7. Fewer Prior Authorization Issues – Of all the responses, 6.4% of the providers expressed no or limited issues or concerns with prior authorizations under FFS were included in this category.
8. Denials Fewer/Simpler – Of all the responses, 4.1% of the providers identified fewer and/or simpler denials of service and/or payment under FFS.
9. No Change from MCOs – Of all the responses, 1.3% of the providers did not see a change or difference between fee-for-service and the MCOs.
10. Not Qualified or Unable to Respond – Of all the responses, 1.0% of the providers believed they were not qualified or able to respond to this topic.
11. Increased Administrative Burden or Costs – Of all the responses, 0.1% of the providers identified an increase in costs to operate as a healthcare provider, or additional burden such as more time or resources under the FFS model.

Schedule 3 summarizes the benefits reported by the providers in each of the provider categories. As illustrated by the **Schedule**, the most common response by providers was they believed FFS was a better program or was better administered when compared to the MCOs (30.8%). As also illustrated by the **Schedule**, the next two most common responses were 23.4% believed the claims processing/payment system of FFS was better followed by 9.2% believed more of the Medicaid population was served, or was better served, under FFS. The remaining categories of responses by the providers are listed in **Schedule 3**.

In addition to identifying benefits, we also inquired about disadvantages of the FFS model when compared to the MCO model. During our review of the providers' responses, we identified the following seven general categories in which the provider responses could be classified

1. No Disadvantage or None Identified/Unsure or No Change – Of all the responses, 44.0% of the providers believed there was no disadvantage, did not identify a disadvantage, were unsure of any disadvantage, or believed there was no change under the FFS model for Medicaid.

2. Program/Administration Difficulties – Of all the responses, 17.9% of the providers believed to be negative programmatic or administration experiences under the FFS model for Medicaid.

3. No or Incomplete Response – Of all the responses, 17.1% of the providers did not provide any information or where the response did not contain information sufficient to determine the content.

4. Payment Inaccuracies/Difficulties or Reduction – Of all the responses, 13.3% of the providers included information concerning experienced inaccuracies, difficulties, and denials with claims, claim payments, or reductions in payments under the FFS model for Medicaid.

5. People or Medicaid Members Less Served – Of all the responses, 3.4% of the providers believed Medicaid members were less served under the FFS model due to such things as fewer people served by Medicaid and less consideration for quality of care.

6. Increased Administrative Burden or Costs – Of all the responses, 2.5% of the providers reported they incurred an increase in costs to operate as a healthcare provider, or additional burden such as more time or resources under the FFS model for Medicaid.

7. Not Qualified or Unable to Respond – Of all the responses, 1.9% of the providers believed they were not qualified or able to respond to this topic.

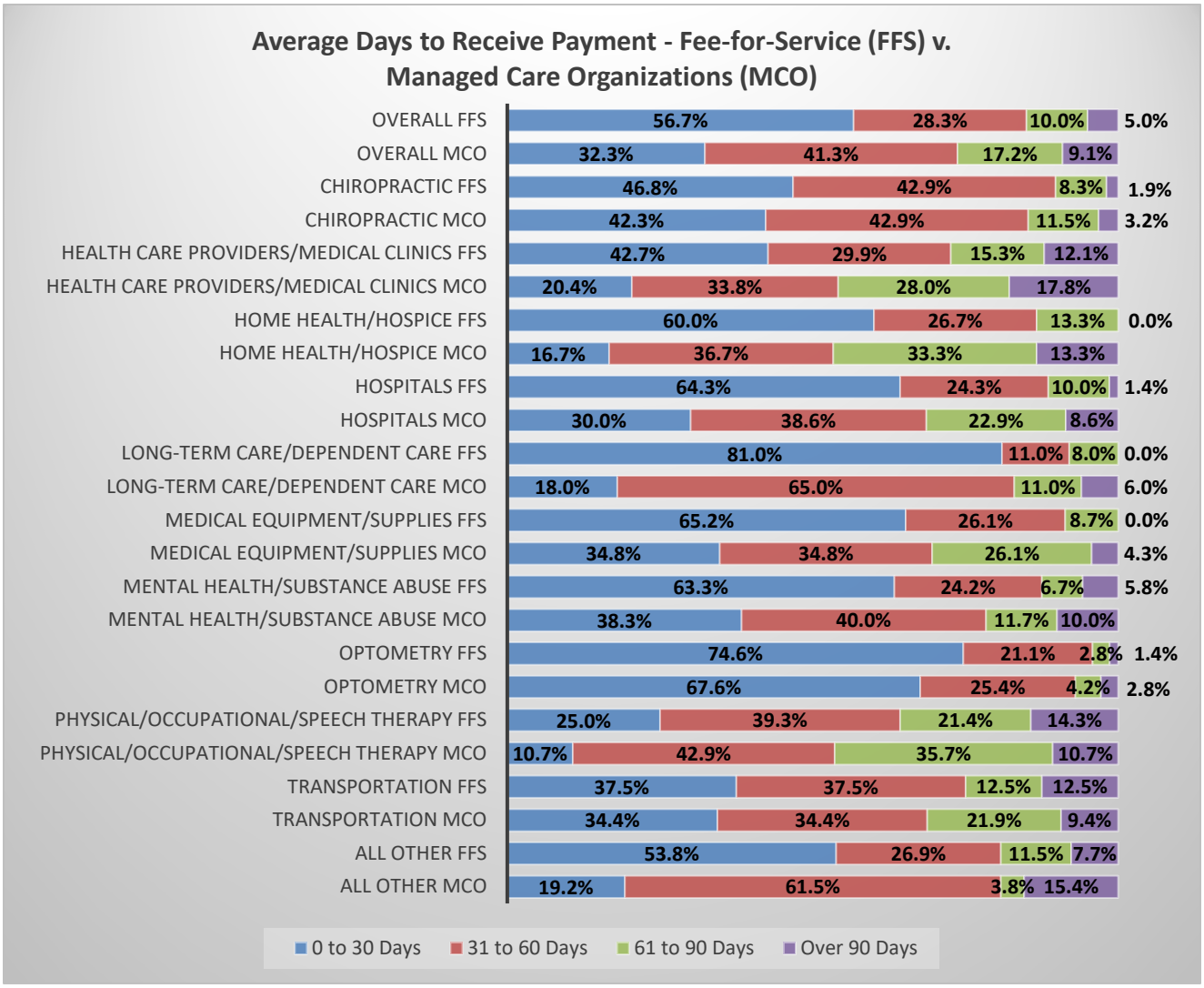
Schedule 4 summarizes the disadvantages reported by the providers in each of the provider categories. As illustrated by the **Schedule**, when given the opportunity to list the disadvantages of the FFS model, the most common response by the providers experienced no disadvantage or did not identify a disadvantage, or were unsure or felt there was no change with the FFS when compared to the MCO model at 44.0%, Also, as illustrated by the **Schedule**, the two other most common responses reported by the providers when describing the disadvantages of the FFS service model were program/administration difficulties (17.9%). The remaining categories of responses by the providers are listed in **Schedule 4**.

Timeliness of Medicaid Payments to Providers

During the survey, the providers were asked to compare the MCO model to the FFS model regarding the average days experienced by the providers to receive their payment for Medicaid services. To carry out this comparison, the providers were asked to answer the following questions: (1) on average, how many days did it take for your organization to receive payments under the FFS model, and (2) on average, how many days does it take for your organization to receive payment from an MCO? The respondent providers were given the following four choices in which to answer each of these questions (a) 0 – 30 days; (b) 31 – 60 days; (c) 61 – 90 days; or (d) 91 days or above.

Of the providers who responded, 56.7% reported they received their Medicaid payment, on average, within 0 to 30 days under FFS. Conversely, 32.3% of providers reported they received their Medicaid payment, on average, within 0 to 30 days under the MCOs. The breakdown of the timeliness of Medicaid payments reported by providers, as measured by average days to receive payment, is listed by provider category in **Tables 12**.

Table 12



As illustrated by the **Table**, the providers in every category reported they received their Medicaid payments in a more timely manner under FFS than under the MCOs. For example, 81.0% of the providers in the category "long-term care/dependent care"% reported receiving Medicaid payments, on average, within 0 to 30 days. However, only 18% of the providers in the same category reported %they received their Medicaid payment, on average, within 0 to 30 days under the MCOs. According to the responses summarized in **Table 12**, majority of the providers reported they received payment from MCOs within 31 to 60 days.

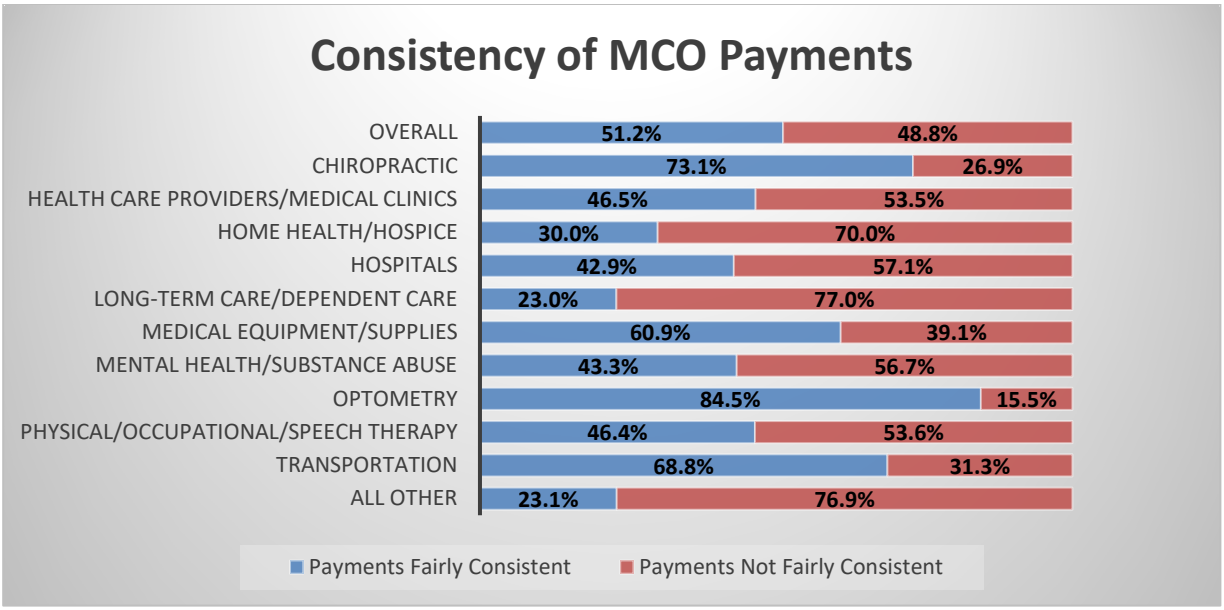
Based on the providers' responses, they were paid in a timelier manner under FFS compared to MCO. **Table 13** compares the percentage of providers which reported being paid within 60 days under the FFS and MCO models. As illustrated by the **Table**, fewer providers reported being paid within 60 days by the MCOs when compared to FFS.

Table 13

Provider Category	0-30 Days		31-60 Days		61 Days or More	
	FFS	MCO	FFS	MCO	FFS	MCO
Overall	56.7%	32.3	28.3	41.3	85.0	73.6
All others	53.8	19.2	26.9	61.5	80.7	80.7
Chiropractic	46.8	42.3	42.9	42.9	89.7	85.2
Health care providers/Medical clinics	42.7	20.4	29.9	33.8	72.6	54.2
Home health/Hospice	60.0	16.7	26.7	36.7	86.7	53.4
Hospitals	64.3	30.0	24.3	38.6	88.6	68.6
Long-term care/ Dependent care	81.0	18.0	11.0	65.0	92.0	83.0
Medical equipment/ supplies	65.2	34.8	26.1	34.8	91.3	69.6
Mental health/ Substance abuse	63.3	38.3	24.2	40.0	87.5	78.3
Optometry	74.6	67.6	21.1	25.4	95.7	93.0
Physical / Occupational / Speech therapy	25.0	10.7	39.3	42.9	64.3	53.6
Transportation	37.5	34.4	37.5	34.4	75.0	68.8

In addition to payment timeliness, the providers were asked if receipt of payments from MCOs have been fairly consistent with regards to the amount of time to receive payment. According to provider data, 51.2% of providers believed receipt of payments from the MCOs has been fairly consistent. However, 48.8% of providers believed receipt of payments from the MCOs has not been fairly consistent. **Table 14** summarizes the providers responses by provider category.

Table 14

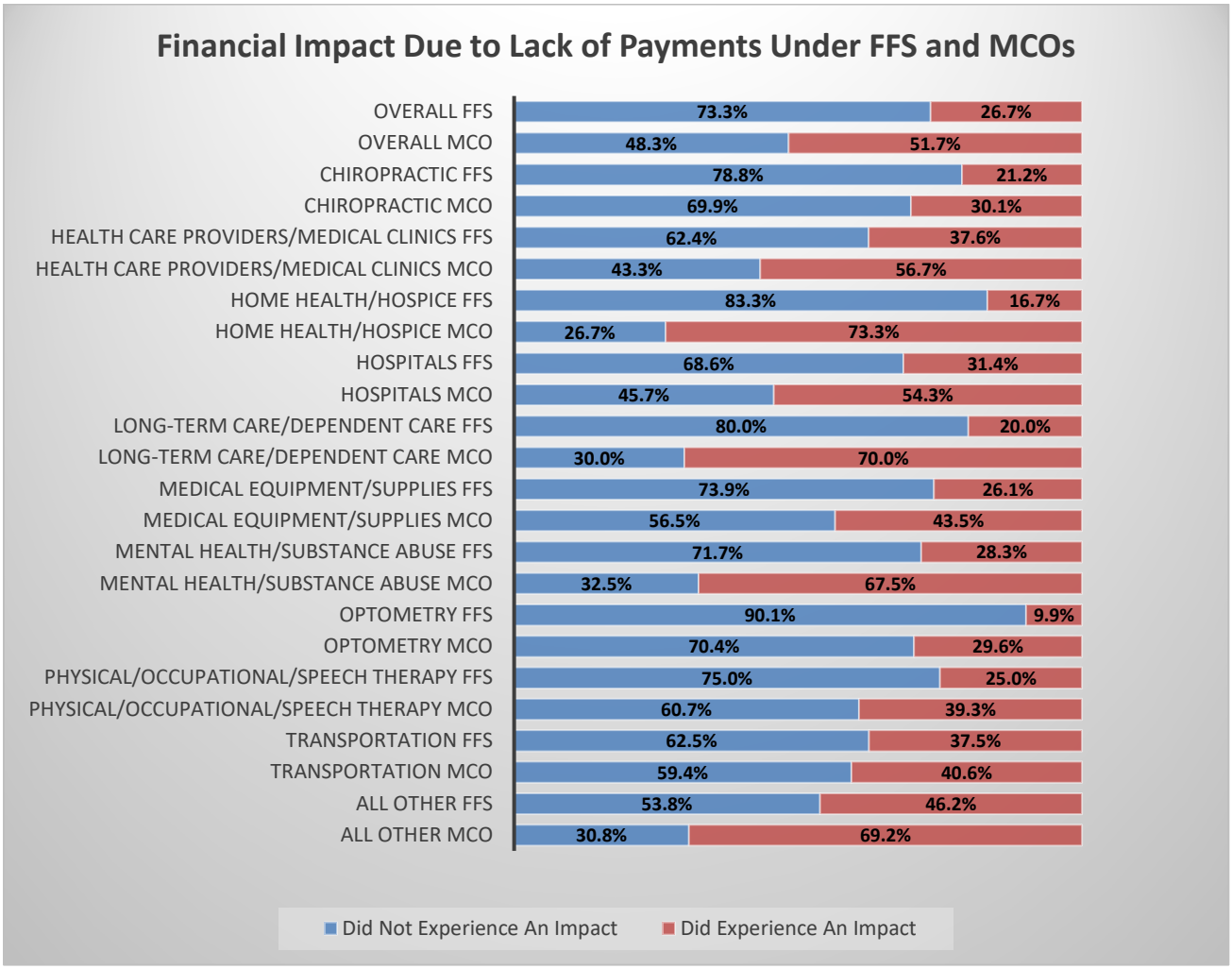


As illustrated by the **Table**, optometry had the highest rate of providers which reported MCO payments were fairly consistent with 84.5%. However, long-term care/dependent care had the highest rate of providers which did not believe MCO payments were fairly consistent with 77.0%.

Financial Impact Due to Lack of Payments

During the survey, providers were asked whether or not they experienced any financial impact due to lack of payments under the former FFS model and the current MCO model for Medicaid. The responses by provider category are summarized in **Table 15**.

Table 15



As illustrated by the **Table**, 73.3% of the providers did not experience a financial impact due to lack of payments under the FFS model while the remaining 26.7% of providers answered they did experience a financial impact. The **Table** also illustrates 48.3% of the providers did not experience a financial impact due to lack of payments under the MCO model. However, 51.7% of providers reported they did experience a financial impact. For the providers who reported they experienced a financial impact, a comment box was provided during the survey to describe the financial impact.

We analyzed the providers' comments to determine the content of the responses and classify them into "general categories." In many instances, the providers' responses included content that applied to several of the general categories. As a result, we classified the provider responses under as many of the general categories as indicated by the content.

As stated previously, the providers were asked to describe experiences regarding financial impact due to lack of payments under FFS. However, several providers described experiences that specifically related to the MCO model. Those responses are also included in the following list of categories describing the providers' responses.

Responses regarding experiences under FFS:

- Claims Not Paid/Decline in Revenue – Of all the responses, 42.5% of the providers experienced situations with getting claims paid or incurred a decline in revenue due to claims not being paid or a decrease in payment amount.
- Increased Administrative Burden or Costs – Of all the responses, 24.0% of the providers reported an increase of administrative burdens or costs due to financial impacts on their practices such as additional staff, more staff time, increased debt or other negative financial impact, or incurred additional procedural burdens related to prior authorizations and delayed credentialing.
- Payment Delays – Of all the responses, 15.7% of the providers experienced delays in their Medicaid payment.
- No or Incomplete Response or Unsure – Of all the responses, 6.5% of the providers did not provide any information, or the response did not contain information sufficient to determine the content or the provider was unsure.

Responses regarding experiences under MCOs:

- Claims Not Paid/Decline in Revenue – Of all the responses, 37.7% of the providers experienced situations with getting claims paid or incurred a decline in revenue due to claims not being paid or a decrease in payment amount.
- Increased Administrative Burden or Costs – Of all the responses, 26.4% of the providers reported an increase of administrative burdens or costs due to financial impacts on their practices such as additional staff, more staff time, increased debt or other negative financial impact, or incurred additional procedural burdens related to such things as delayed credentialing.
- Payment Delays – Of all the responses, 13.1% of the providers experienced delays in their Medicaid payment.
- No or Incomplete Response or Unsure – Of all the responses, 6.9% of the providers did not provide any information, or the response did not contain information sufficient to determine the content or the provider was unsure.
- Negative Feedback Iowa Total Care – Of all the responses, 5.8% of the providers included negative feedback specific to the MCO Iowa Total Care. For example, one health care/medical clinic provider's negative response while completing the survey in late 2019 regarding Iowa Total Care was, "we still are waiting on payments from ITC for services done from initial effective dates July 1st…we are NOT getting paid for ANY of our claims!!!!"
- Prior Authorization Issues/Delays – Of all the responses, 3.3% of the providers experienced such things as increased prior authorization requirements, burdensome prior authorization requirements, or delays in approvals of prior authorizations.
- Negative Feedback UnitedHealthcare – Of all the responses, 2.9% of the providers included negative feedback specific to the MCO UnitedHealthcare. For example, one health care/medical clinic provider's negative response regarding UnitedHealthcare was, "United healthcare was hard to get payments from, when they closed, and we inquired about nonpayment of claims they acted like they never received them and it was now past timely filing."

- Negative Feedback Amerigroup – Of all the responses, 2.2% of the providers included negative feedback specific to the MCO Amerigroup. For example, one mental health/substance abuse provider's negative response regarding Amerigroup was, "I had to stop taking clients with Amerigroup because I had no income coming in, 6 months of no payment and no answers from them."

- Negative Feedback AmeriHealth – Of all the responses, 1.7% of the providers included negative feedback specific to the MCO AmeriHealth. For example, one mental health/substance abuse provider's negative response regarding AmeriHealth was, "we were owed over $30,000 from AmeriHealth Caritas for over a year, before we got everything settled. We are a small agency and $30,000 for us can mean not being able to make payroll."

Additional responses regarding experiences under MCOs:

- Negative Feedback Amerigroup – Of all the responses, 3.4% of the providers included negative feedback specific to the MCO Amerigroup. For example, one hospital provider's negative response regarding Amerigroup was, "we wrote approximately $60k in ambulance charges as Amerigroup could not get their own rules figured out."

- Negative Feedback AmeriHealth – Of all the responses, 2.2% of the providers included negative feedback specific to the MCO AmeriHealth. For example, one mental health/substance abuse provider's negative response regarding AmeriHealth was, "Caritas paid us the wrong rate for several months, did not listen to our requests for correction until we contacted the Ombudsman's office. Then it took several more months for them to make the correction. They were little help with billing issues and did not use the standard billing form- it needed many special codes which was difficult for our small office to manage."

- Negative Feedback UnitedHealthcare – Of all the responses, 2.5% of the providers included negative feedback specific to the MCO UnitedHealthcare. For example, one mental health/substance abuse provider's negative response regarding UnitedHealthcare was, "United Healthcare cost the center thousands of dollars in posting, recouping, arguing with them on what was owed to us. They didn't acknowledge they owed us anything until we filed a complaint with IME. They tend to short pay and take a while for projects (to) get completed, so when claims are reprocessed after being in a project, it's past timely filing."

- Positive Feedback Iowa Total Care – Of all the responses, 0.3% of the providers included positive feedback specific to the MCO Iowa Total Care. For example, a health care/medical clinic provider's positive response regarding Iowa Total Care was, "[a previous] MCO would not respond to requests to participate and then once they did we were not informed when our physicians were approved. So, you have patients with appointments and the physicians are not yet on the plan. Iowa Total Care much better."

- Negative Feedback Iowa Total Care – Of all the responses, 3.1% of the providers included negative feedback specific to the MCO Iowa Total Care. For example, one long-term care/dependent care provider's negative response regarding Iowa Total Care was, "we are delaying payments to our vendors because we are waiting for payment from MCOs. As of today, Iowa Total Care has not paid us ANYTHING since their inception. And there is no recourse for this."

Schedule 5 summarizes the financial impacts reported by the providers due to lack of payment under the FFS model by each of the provider categories. As illustrated by the **Schedule**, for the 26.7% of providers who experienced a financial impact, the most common response was the impact was related to claims not being paid and/or revenue declined (42.5%). In addition, the **Schedule** shows the next most common responses were the impact increased administrative burden or costs

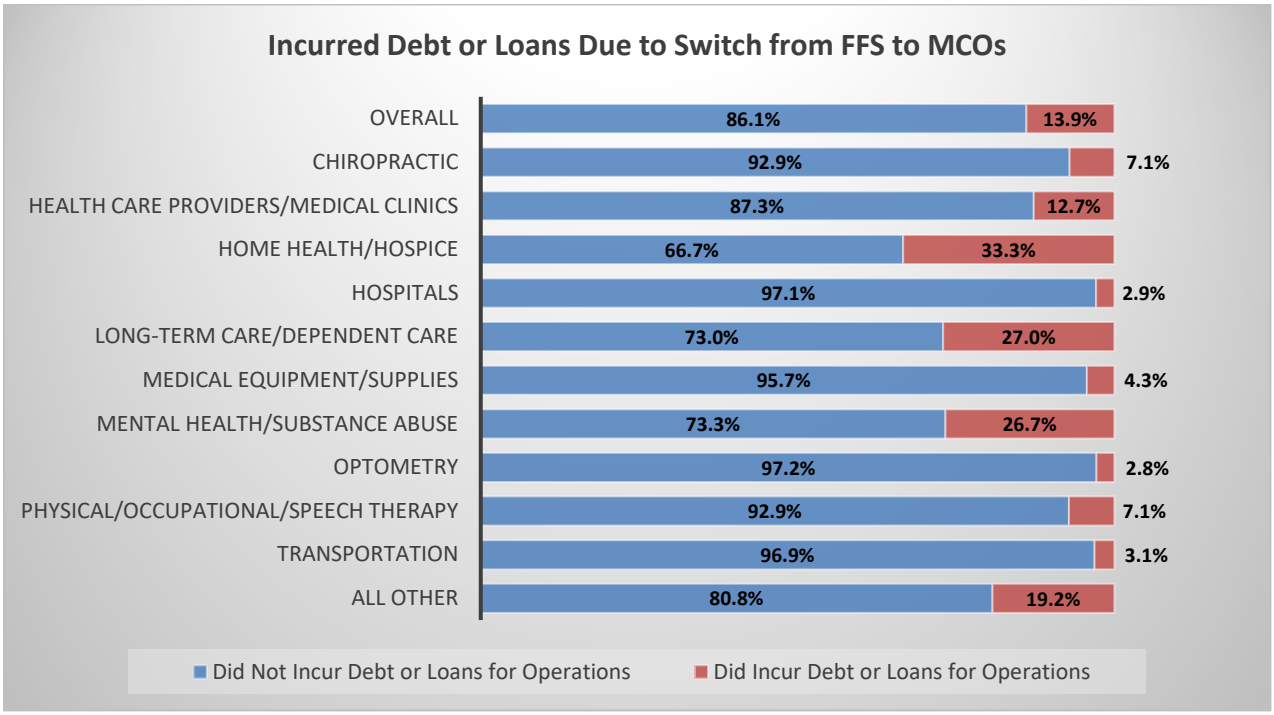
on providers (24.0%) and payment delays (15.7%). The remaining categories of responses by the impacted providers are summarized in **Schedule 5**.

Schedule 6 summarizes the financial impacts reported by the providers due to lack of payment under the MCO model by each of the provider categories. As illustrated by the **Schedule**, of the 51.7% of providers who experienced a financial impact, the most common response was the impact was related to claims not being paid and/or revenue declined (37.7%). In addition, the **Schedule** also showed the next most common responses were increased administrative burden or costs on providers (26.4%) and payment delays (13.1%). The remaining categories of responses by the impacted providers are summarized in **Schedule 6**.

Debt or Loans Due to Switch from FFS to MCOs

In addition to asking providers to disclose financial information regarding the amount of payments due from the MCOs which was outstanding 90 days or more, we asked providers if they incurred any debt or loans to continue their operations as a result of the switch FFS to the MCO model for Medicaid. **Table 16** summarizes the responses of this question.

Table 16



As illustrated by the **Table**, 86.1% of the providers did not incur debt or loans to continue operations while 13.9% did incur debt or loans as a result of the switch from FFS to the MCO model for Medicaid. For the providers who reported they incurred debt or loans to continue operations, a comment box was provided during the survey to describe the financial impact.

We analyzed the providers' comments to determine the content of the responses and classify them into "general categories." In many instances, the providers' responses included content that applied to several of the general categories. As a result, we classified the provider responses under as many of the general categories as indicated by the content. During our review, we identified six general categories in which the providers' responses could be classified as follows:

1. Business Loan/LOC/Debt – Of all the responses, 38.0% of the providers described having to obtain business loans, lines of credit (LOC), or incurring business debt in order to continue operations and/or deal with cash flow issues related to delayed payments by the MCOs.

2. Claims not Paid/are Delayed or Lower Reimbursement – Of all the responses, 31.9% of the providers reported claims not being paid and/or were delayed, or lower reimbursement by the MCOs as leading to financial difficulties such as incurring debt and/or loans in order to continue operations.

3. Other Funding Sources Used – Of all the responses, 12.0% of the providers reported obtaining loans or funds from other sources sch as other business funding streams or personal loans/funds in order to continue operations.

4. Difficulty with Payroll – Of all the responses, 7.2% of the providers responses included difficulties with making payroll relating to the switch to the MCOs were included in this category.

5. No or Incomplete Response or Unsure – Of all the responses, 6.6% of the providers did not provide any information, or the response did not contain information sufficient to determine the content or the provider was unsure.

6. Difficult/Late to Pay Bills or Incurred Late Fees or Interest – Of all the responses, 4.2% of the providers experienced difficulty to pay bills, late to pay bills, and/or incurred late fees or interest in conjunction with this activity.

Schedule 7 summarizes the type of debt or loans incurred to continue operations due to the change from FFS to the MCOs. As illustrated by the **Schedule**, for the 13.9% of providers who incurred debt or loans, the most common response was the providers incurred business loan, line(s) of credit, or other debt (38.0%) to continue operations and deal with such things as cash flow issues. In addition, the **Schedule** illustrates the second most common response was the providers reported claims were not paid or were delayed or the providers incurred lower reimbursement and experienced financial difficulties (31.9%). The remaining categories of responses by the impacted providers are listed in **Schedule 7**.

Terminating and Hiring Employees Due to the Privatization of Medicaid

The providers surveyed were asked to provide feedback regarding the impact the privatization of Medicaid had on terminating and hiring of employees. Specifically, the providers were asked, (1) to provide the total number of employees terminated if they had to terminate employees due to the privatization of Medicaid, and (2) to provide the total number employees hired if they increased staffing levels due to the privatization of Medicaid. A comment box was provided during the survey to allow providers to describe their experiences with terminating and hiring employees.

We analyzed the providers' comments regarding employee terminations to determine the content of the responses and classify them into "general categories." During our review, we identified four general categories in which the provider responses could be classified for employee termination which are as follows:

1. Terminated Employees – providers that reported terminating employees due to the privatization of Medicaid.

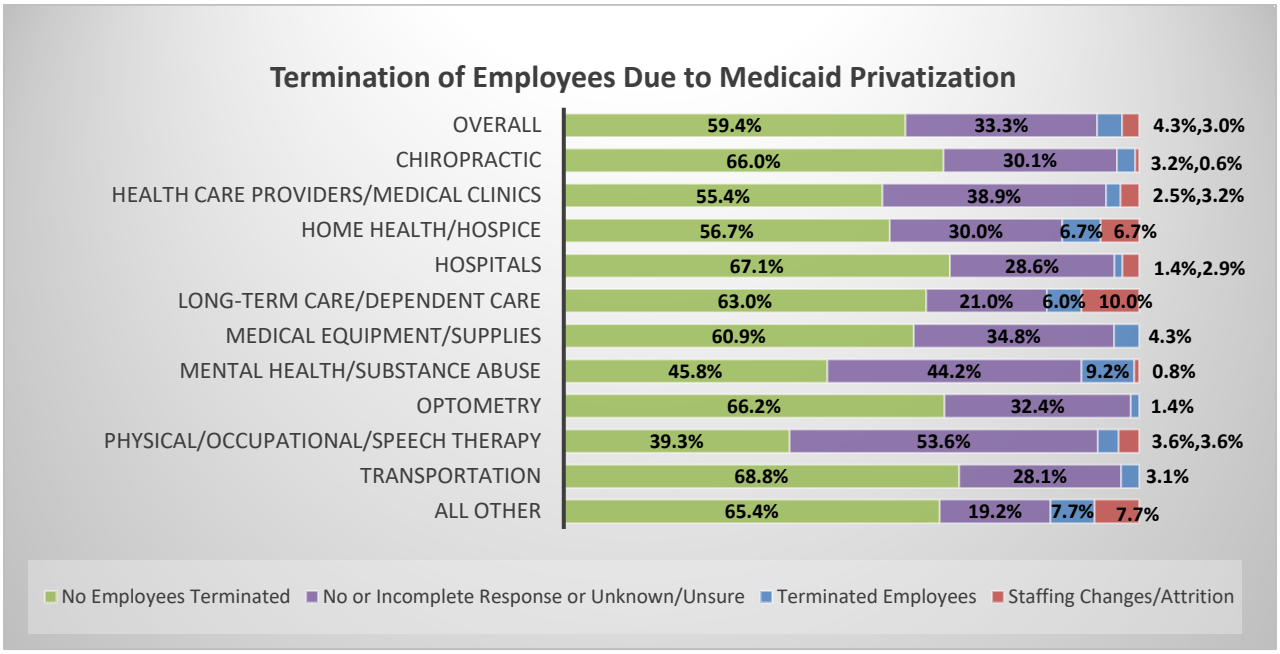
2. Staffing Changes/Attrition – providers in this category described having to make changes within existing staff and/or reducing staff levels through attrition due to the privatization of Medicaid.

3. No Employees Terminated – providers in this category reported they did not terminate employees as a result of the privatization of Medicaid.

4. No or Incomplete Response or Unknown or Not Applicable – providers that did not provide a response, provided an incomplete response, did not know how to respond, or responded the question was not applicable to them.

Table 17 summarizes the experiences by provider category concerning provider termination of employees.

Table 17



As illustrated by the **Table**, 4.3% of providers stated they terminated employees while 59.4% of providers overall reported they did not terminate employees due to the privatization of Medicaid. Overall, 5.3% of providers made staffing changes within current staff to include reductions in staff through attrition. Also as illustrated by the **Table**, 33.3%, did not provide a response, provided an incomplete response, did not know how to respond, or responded the question was not applicable to them.

In addition to reviewing the providers' responses regarding employee termination, we analyzed the providers' responses regarding the hiring of employees to determine the content of the responses and classify them into "general categories." During our review, we identified four general categories in which the provider responses could be classified for hiring employees which are as follows:

1. Hired Employees –providers that identified as having hired employees due to the privatization of Medicaid.

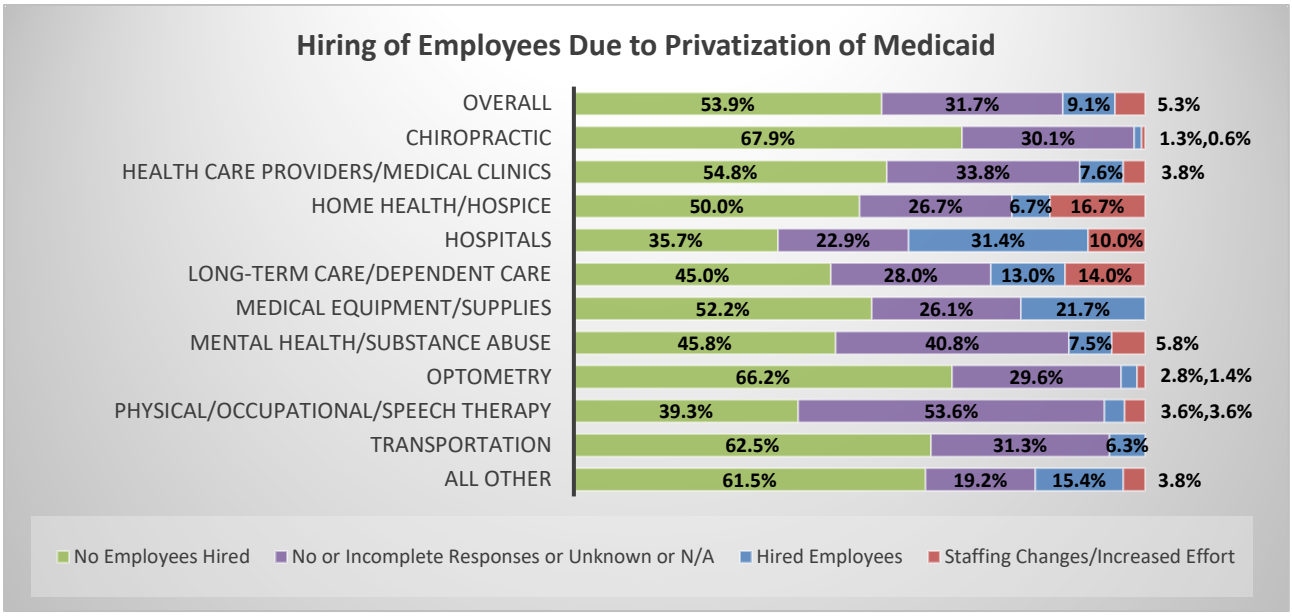
2. Staffing Changes/Increased Effort – providers in this category described having to make staff changes within existing staff and/or increasing staff effort as a result of the privatization of Medicaid.

3. No Employees Hired – providers in this category reported they did not hire employees as a result of the privatization of Medicaid.

4. No or Incomplete Response or Unknown or Not Applicable – providers that did not provide a response, provided an incomplete response, did not know how to respond, or responded the question was not applicable to them.

Table 18 summarizes the experiences by provider category concerning hiring employees due to the privatization of Medicaid.

Table 18



As illustrated by the **Table**, 9.1% of providers reported they hired employees while 53.9% of providers overall did not hire employees due to the privatization of Medicaid. Overall, 5.3% of providers made staffing changes within current staff to include increased staff effort. Also, 31.7%, did not provide a response, provided an incomplete response, did not know how to respond, or responded the question was not applicable to them.

For the providers who terminated or hired employees and provided a specific total amount of employees, **Table 19** summarizes the amounts reported by provider category.

Table 19

Provider Category	Number of FTEs* Terminated	Number of FTEs* Hired
All Other	4.0	7.0
Chiropractic	19.5	2.0
Health Care Providers/Medical Clinics	22.0	22.0
Home Health/Hospice	24.0	11.0
Hospitals	1.0	98.5
Long-term Care/Dependent Care	59.0	66.5
Medical Equipment/Supplies	1.0	10.0
Mental Health/Substance Abuse	62.0	25.0
Optometry	2.0	2.0
Physical/Occupational/Speech Therapy	1.0	1.0
Transportation	1.0	3.0
Overall (Total)	196.5	248.0

* - Number of full time equivalent positions.

As illustrated by the **Table**, providers reported terminating 196.50 full time equivalent positions as a result of privatization of Medicaid. However, the providers reported hiring 248.00 full time equivalent positions as a result of the privatization of Medicaid. In addition, as illustrated by the **Table**, the majority of the reported FTEs hired were attributed to hospital and long-term care/dependent care providers. Sufficient data was not available to determine whether the reason the jobs were added was positive or negative.

Provider Changes in the Number of Medicaid Members Served

During the survey, providers were asked questions regarding any changes in the number of Medicaid members served by the providers and their organizations. Specifically, the providers were asked:

(1) Due to potential late payments provided by the MCOs, have you decreased the number of Medicaid member served by your organization?

(2) Was the decision to increase or decrease the number of Medicaid patients served:

(a) decided by the provider's organization, or

(b) due to factors beyond the organization's control?

(3) Has your organization stopped providing services to Medicaid members?

The providers were given the opportunity to answer "yes" or "no" to this survey question. If providers answered "yes", they were asked if they stopped providing services to Medicaid member due to any of the following:

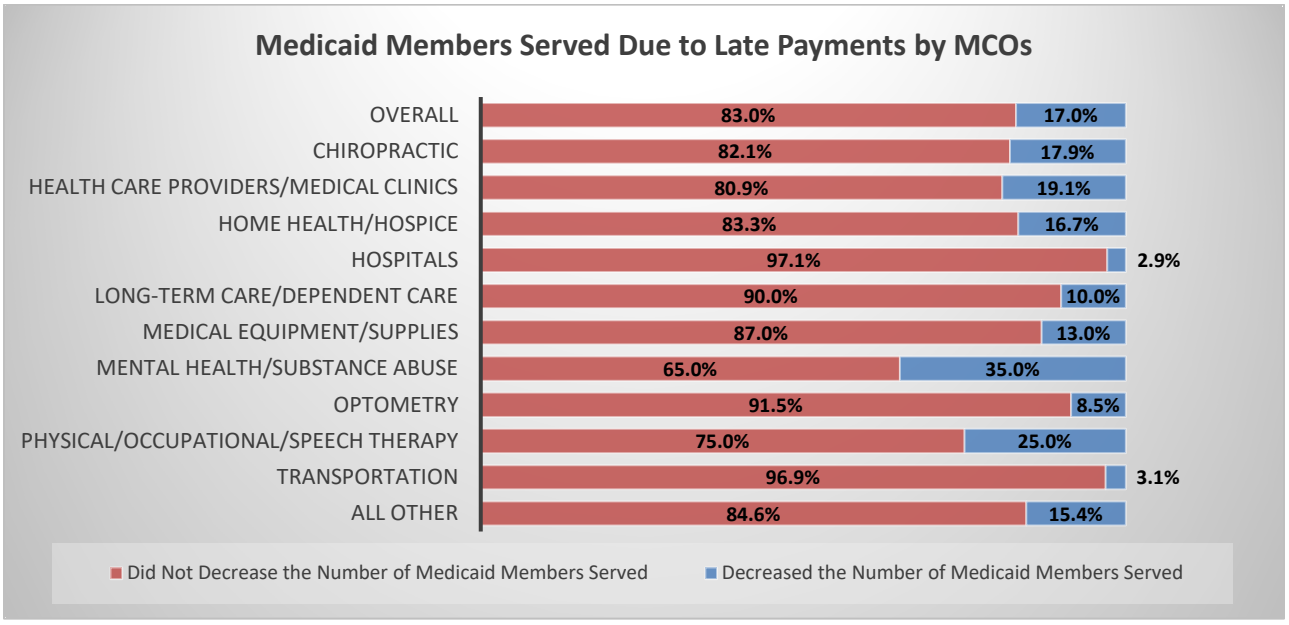
(a) Unable to financially sustain providing services to Medicaid members;

(b) Unable to comply with contract terms under the Medicaid MCOs; or

(c) Other. Providers answering "other" were asked to explain any details.

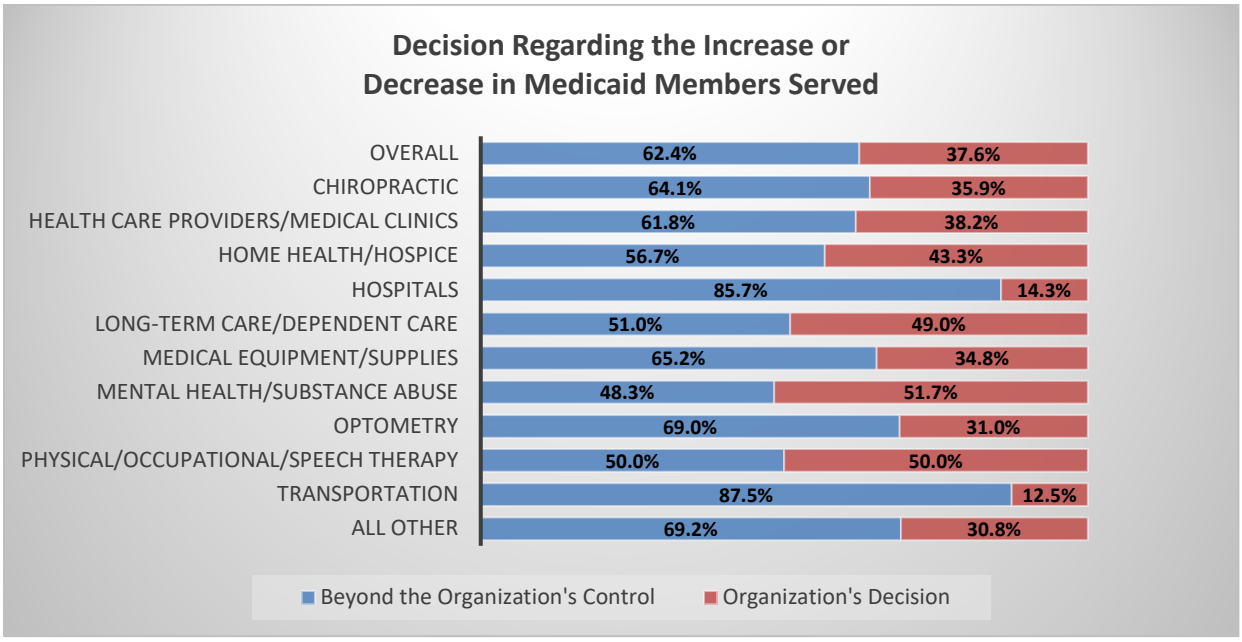
In response to the question regarding whether providers decreased the number of Medicaid members served, 83.0% of the providers reported they did not decrease the number of Medicaid members served. However, 17.0% of the providers reported they did decrease the number of Medicaid members served. The breakdown by provider category is summarized in **Table 20**.

Table 20



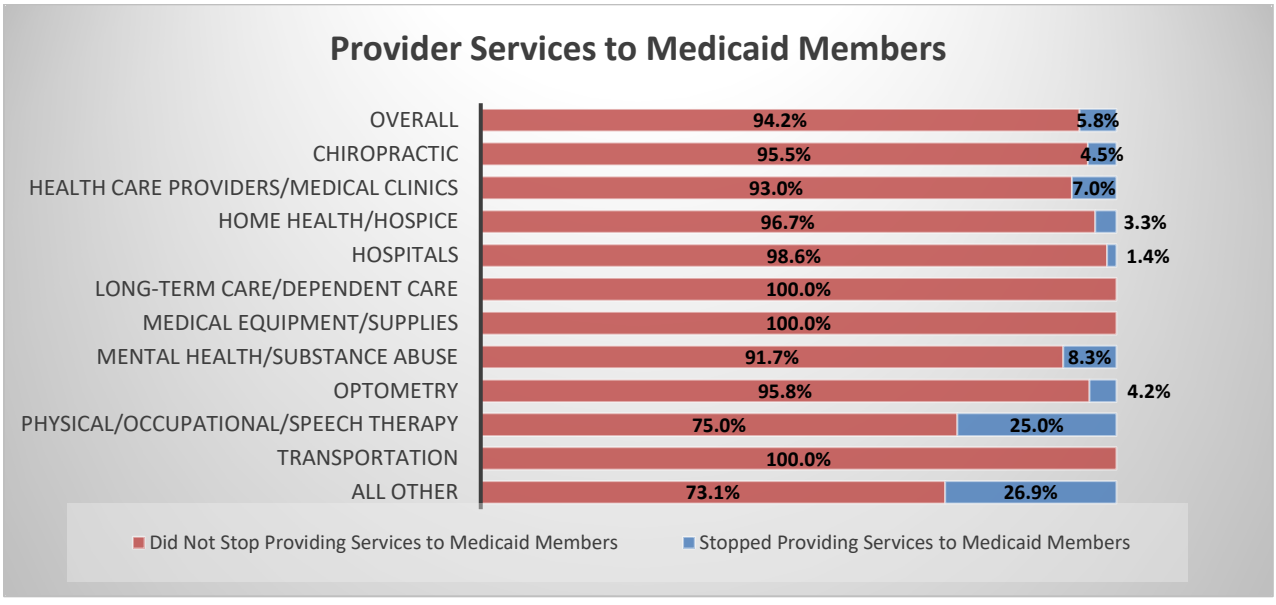
In response to the question regarding the decision to increase or decrease the number of Medicaid patients served being (a) decided by the provider's organization, or (b) factors beyond the organization's control, 62.4% of the providers reported the decision was beyond the organization's control. However, 37.6% of the providers reported the decision was made by the provider's organization. The breakdown by provider category is summarized in **Table 21**.

Table 21



In response to the question regarding whether the providers have discontinued services to Medicaid members, 94.2% of the providers reported they have not stopped providing services to Medicaid members. However, only 5.8% of providers overall related they have stopped providing services to Medicaid members. The breakdown by provider category is summarized in **Table 22**.

Table 22



As illustrated by the **Table**, 5.8% of providers who responded stated they stopped providing services to Medicaid members. These providers were asked follow up questions which included (a) being unable to financially sustain providing services to Medicaid members, (b) being unable to comply

with contract terms under the Medicaid MCOs, or (c) some other reason with an explanation for such responses. Of the responses for these 5.8% of providers, 42.6% reported they stopped seeing Medicaid members because they were financially unable to sustain Medicaid members as patients, 8.5% were unable to comply with contract terms of the MCOs, and the remaining 48.9% answered with some "other" reason.

We reviewed the providers' responses citing "other" reasons for not providing services to Medicaid members to determine the content of the responses and classify them into "general categories." During our review, we identified six general categories in which the provider responses could be classified as follows:

1. No Response – providers who did not provide a response.
2. Provider Application/Credentialing – providers who identified difficulties in becoming a provider with the MCOs either through the application or credentialing process.
3. Increased Administrative Burden or Costs – providers who identified increased administrative costs or burdens as reasons why they no longer serve Medicaid members.
4. Payment Difficulties/Low Reimbursement – providers who identified such things as payment difficulties and low reimbursements as why they no longer serve Medicaid members.
5. Prior Authorization Issues – providers having difficulty with prior authorizations such that they no longer serve Medicaid members.
6. Closed/Retired – providers that no longer serve Medicaid members because they closed their practice or retired.

Schedule 8 summarizes results for the 5.8% of providers who reported they stopped providing services to Medicaid members. As illustrated by the **Schedule**, the most common reason (34.8%) was the increased administrative burden or costs in providing services to Medicaid members. The remaining categories of responses are summarized in **Schedule 8**.

Provider Changes in Costs Due to the Privatization of Medicaid

During the survey, respondent providers were asked to provide a range or exact amount of costs, or changed costs, which were incurred due to the privatization of the Medicaid program. Specifically, the providers were asked to provide the changed costs for four different areas of business operations: (1) medical staff, (2) administrative staff, (3) write-offs for uncollectible fees, and (4) write-offs for additional equipment. A comment box was provided for providers for describe their experience.

We analyzed the providers' comments to determine the content of the responses and classify them into "general categories." During our review, we identified four general categories in which the provider responses could be classified as follows:

1. No or Incomplete Response or Unknown/Unsure – providers who did not provide a response to the survey question, provided an incomplete response, did not know a response, or were unsure of a response.

2. Responded with Zero – providers who responded they incurred zero cost or experience no changed costs as a result of the privatization of Medicaid.

3. Responded with a Single, Annual, or Monthly Amount – providers who explained their incurred cots with one amount, an annual amount, or a monthly amount. A few providers used a range of costs and in these instances, we used the high end of the range as the provider's single amount for incurred changed costs.

4. Responded with Other Amount – providers who explained their incurred costs with some type of description other than a single, annual, or monthly amount, such as a percentage basis.

Schedules 9 through **12** summarize the changed costs reported by each provider category with one **Schedule** for each of the four areas of business operations of medical staff, administrative staff, write-offs for uncollectible fees, and write-offs for additional equipment. In summary, **Schedules 9** through **12** illustrate:

- **Schedule 9** – Changed Costs Due to the Privatization of Medicaid-Medical Staff – 99.1% of the responding providers did not answer the survey question, provided an incomplete response, did not know a response, or were unsure of a response. In addition, 0.2% of the providers responded they incurred zero costs, 0.1% provided an "other" amount, and 0.5% responded they incurred costs of a single, annual, or monthly amount due to the privatization of Medicaid.

- **Schedule 10** – Changed Costs Due to the Privatization of Medicaid-Administrative Staff –58.8% of the responding providers did not answer the survey question, provided an incomplete response, did not know a response, or were unsure of a response. In addition, 15.4% of the providers responded they incurred zero costs, 4.7% provided an "other" amount, and 21.2% responded they incurred costs of a single, annual, or monthly amount due to the privatization of Medicaid.

- **Schedule 11** – Changed Costs Due to the Privatization of Medicaid-Write-offs for Uncollectible Fees –59.8% of the responding providers did not answer the survey question, provided an incomplete response, did not know a response, or were unsure of a response. In addition, 13.7% of the providers responded they incurred zero costs, 5.0% provided an "other" amount, and 21.5% responded they incurred costs of a single, annual, or monthly amount due to the privatization of Medicaid.
- **Schedule 12** – Changed Costs Due to the Privatization of Medicaid-Write-offs for Additional Equipment –53.8% of the responding providers did answer the survey question, provided an incomplete response, did not know a response, or were unsure of a response. In addition, 31.4% of the providers responded they incurred zero costs, 0.6% provided an "other" amount, and 14.3% responded they incurred costs of a single, annual, or monthly amount due to the privatization of Medicaid.

As illustrated by the **Schedules**, the providers reported most of their changed costs due to the privatization of Medicaid in the business operations regarding administrative staff and write-offs for uncollectible fees.

Changes in Services Allowed, Covered, or Denied for Medicaid Members by MCOs

During the survey, providers were asked to answer questions regarding their experience with changes in services for Medicaid members relative to the switch from the FFS model to the MCO model. Specifically, the providers were asked:

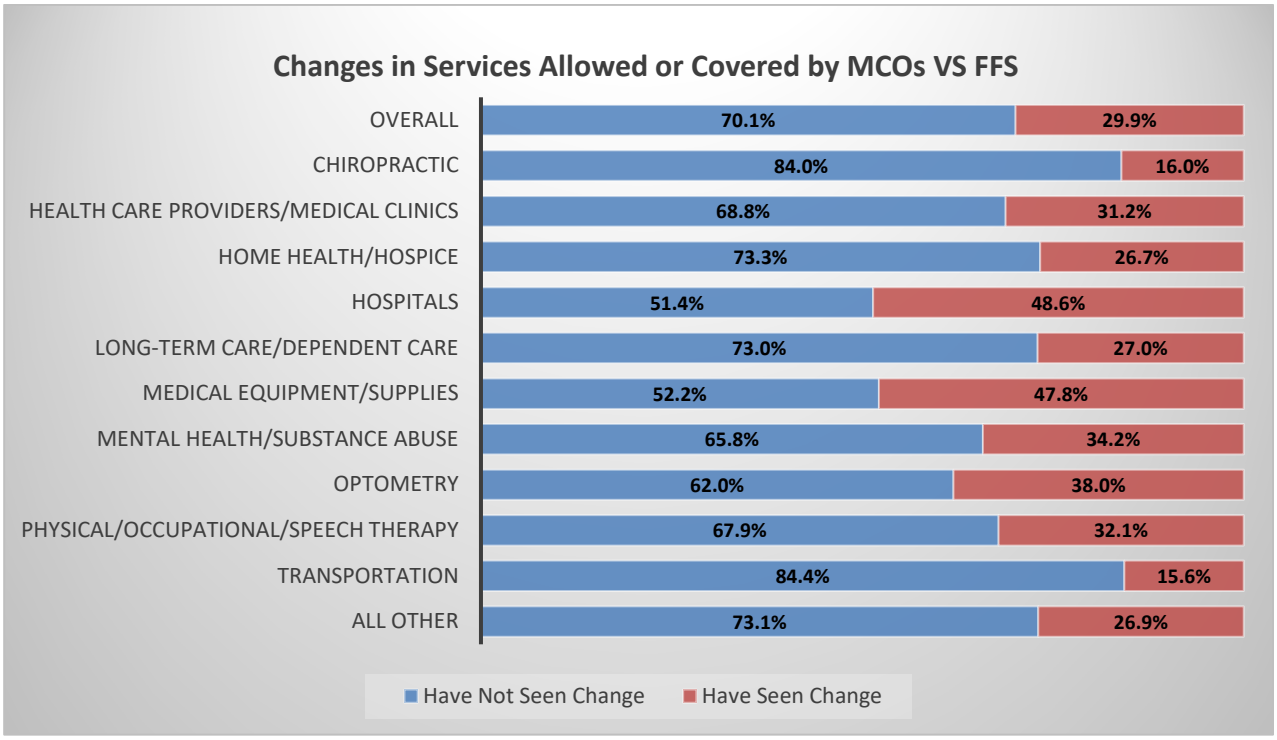
(1) Has your entity seen a change in services allowed or covered by MCOs which were/were not covered by the FFS model? The providers were given the opportunity to answer "yes" or "no" to this survey question. Providers that answered "yes" were asked to explain the changes that have occurred.

(2) Has your entity seen a change in services denied to Medicaid patients by MCOs? The providers were given the opportunity to answer "yes" or "no" to this survey question.

In response to the question regarding whether providers saw a change in services allowed or covered by MCOs which were/were not covered by FFS, 70.1% of the providers reported they have not seen a change. However, 29.9% of providers reported they have seen a change in service allowed or

covered by MCOs compared to the FFS model. The breakdown by provider category is summarized in **Table 23**.

Table 23



The 29.9% of providers who responded they have seen a change in services allowed or covered by MCOs were asked, as stated earlier, to explain the changes that have occurred. We reviewed the providers' responses to determine the content and classify them into "general categories." During our review, we identified eleven general categories in which the provider responses could be classified as follows. However, many of the providers' responses containing feedback applied to several of the general categories; therefore, we included the provider responses under as many of the general categories as applicable.

1. MCO Coverage Issues/Less Coverage – Of all the responses, 34.6% of the providers responses included problems with MCO coverage, or there is less coverage provided under the MCOs than FFS.
2. MCO Preauthorization Issues/Burdensome Requirements – Of all the responses, 21.5% of the provider responses included implemented prior authorization procedures and burdensome requirements with these prior authorizations as a change that has occurred with the initiation of the MCOs.
3. MCO Payment Issues/Denials/Less Reimbursement – Of all the responses, 12.5% of the providers experienced such things as difficulty with payments, denials of payment, or a decrease in payment amount with the MCOs versus FFS.
4. No or Incomplete Response or Unknown/Unsure – Of all the responses, 10.7% of the providers did not provide any information, or the response did not contain information sufficient to determine the content or the provider did not know a response or was unsure.
5. Patients Less Served –Of all the responses, 4.8% of the providers reported patients being less served as change that occurred with the switch from FFS to the MCOs.
6. MCO Better Coverage/Reimbursement – Of all the responses, 1.8% of the providers identified the MCOs as having better coverage or reimbursement were included in this category.

7. MCO Provider Enrollment Issues – Of all the responses, 0.9% of the providers responses included difficulties in enrolling as a provider with the MCOs.

8. Negative Feedback Amerigroup – Of all the responses, 8.4% of the providers included negative feedback specific to the MCO Amerigroup. As an example, a provider explained how pap smears were covered one time per year under FFS, but Amerigroup covered them once every three (3) years.

9. Negative Feedback Iowa Total Care – Of all the responses, 3.6% of the providers included negative feedback specific to the MCO Iowa Total Care. As an example, a provider reported Iowa Total Care does not consistently pay for orthotics.

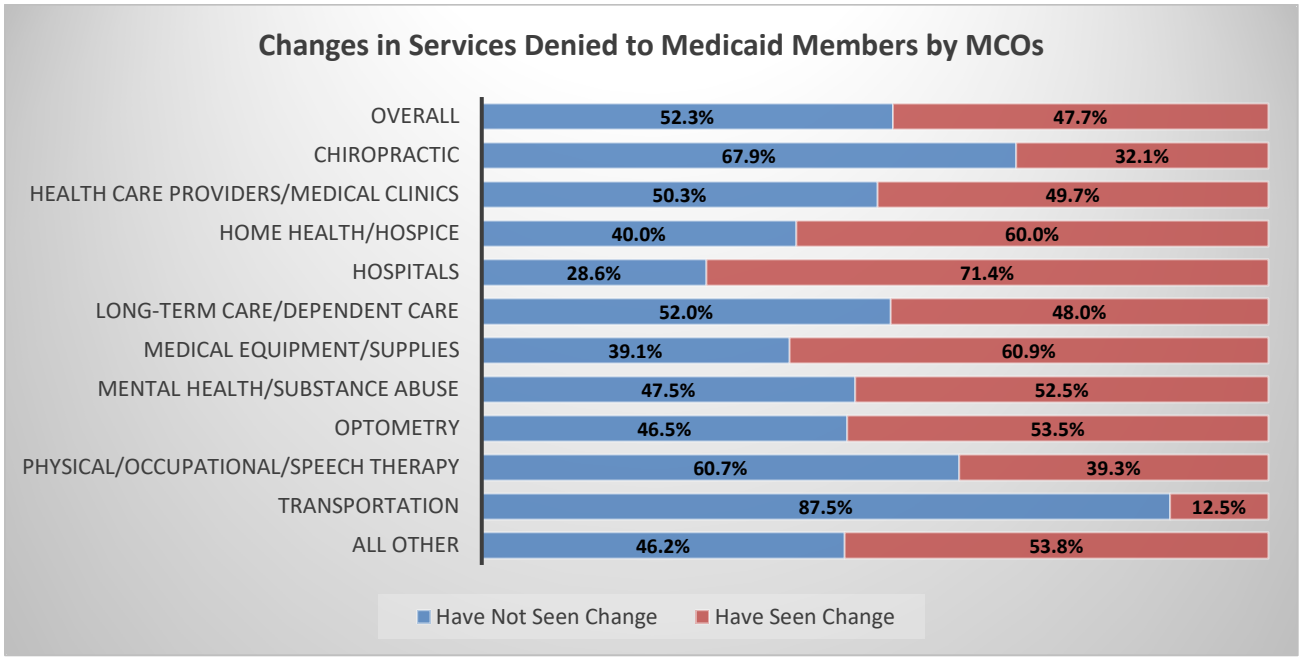
10. Positive Feedback Iowa Total Care – Of all the responses, 0.6% of the providers included positive feedback specific to the MCO Iowa Total Care. As an example, a provider advised "Iowa Total care will cover infusion in the clinic at Medicare rates. We were able to negotiate this as they recognize the cost savings of treating the patient in a clinic setting rather than hospital outpatient. IME and Amerigroup have not been responsive to this approach."

11. Negative Feedback UnitedHealthcare – Of all the responses, 0.6% of the providers included negative feedback specific to the MCO UnitedHealthcare. As an example, a provider explained UnitedHealthcare required pre-authorizations for patients receiving mental health therapy on a weekly basis, then informed the provider the patients could not be seen weekly and any therapy sessions had to be limited to 45 minutes.

Schedule 13 summarizes the changes in services or allowed services reported by providers. As illustrated by the **Schedule**, the most common change (34.6%) related to problems with MCO coverage or there was less coverage under the MCOs. In addition, other common responses included: MCO preauthorization problems or burdensome requirements (21.5%) and changes with MCO payments, denials, or less reimbursement (12.5%). The remaining categories of responses by the impacted providers are summarized in **Schedule 13**.

We also analyzed the responses for the survey question asking providers if they have seen a change in denied services to Medicaid members by MCOs. Of the responding providers, 52.3% reported they have not seen a change. However, 47.7% of providers reported they have seen a change in denied services to Medicaid members by the MCOs. The breakdown by provider category is summarized in **Table 24**.

Table 24



Privatization of Medicaid Impact on Quality of and Access to Care for Medicaid Members

The providers surveyed were asked for responses to two questions regarding their experience with the MCOs relative to the privatization of Medicaid and the impact on Medicaid members. Specifically, the providers were asked:

- How does your entity believe the change to privatized Medicaid has impacted the quality of medical care and attention people receive, and;
- How does your entity believe the change to privatized Medicaid has impacted the access of medical care and attention people have?

The providers were given five options to answer each of the questions:

(a) harmed or impeded significantly,

(b) harmed or impeded somewhat,

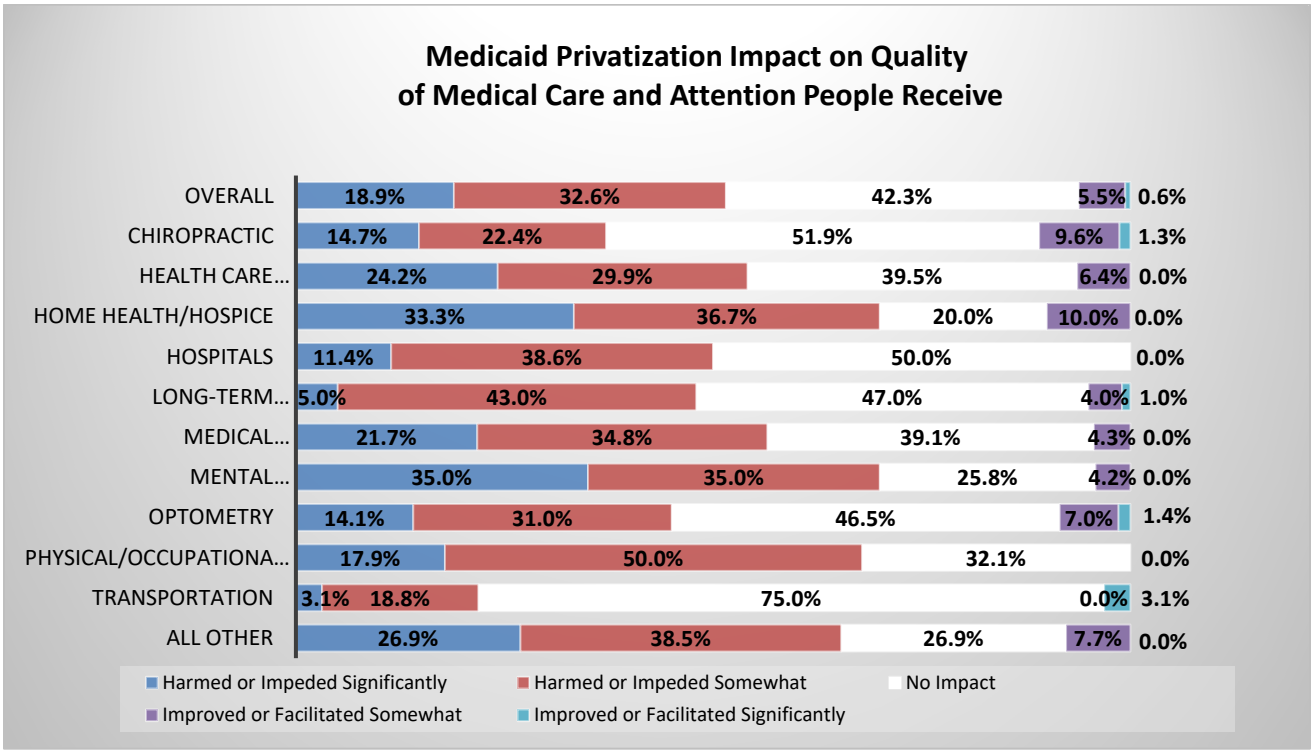
(c) no impact,

(d) improved or facilitated somewhat, and

(e) improved or facilitated significantly.

Of the responding providers, 51.5% reported they believed the privatization of Medicaid has harmed or impeded somewhat or significantly member quality of care, 42.3% believed there has been no impact, and 6.2% of the providers believe privatization has improved or facilitated somewhat or significantly the quality of care for members. The breakdown of provider experience with the privatization of Medicaid and its impact on member quality of care is summarized by provider category in **Table 25**.

Table 25

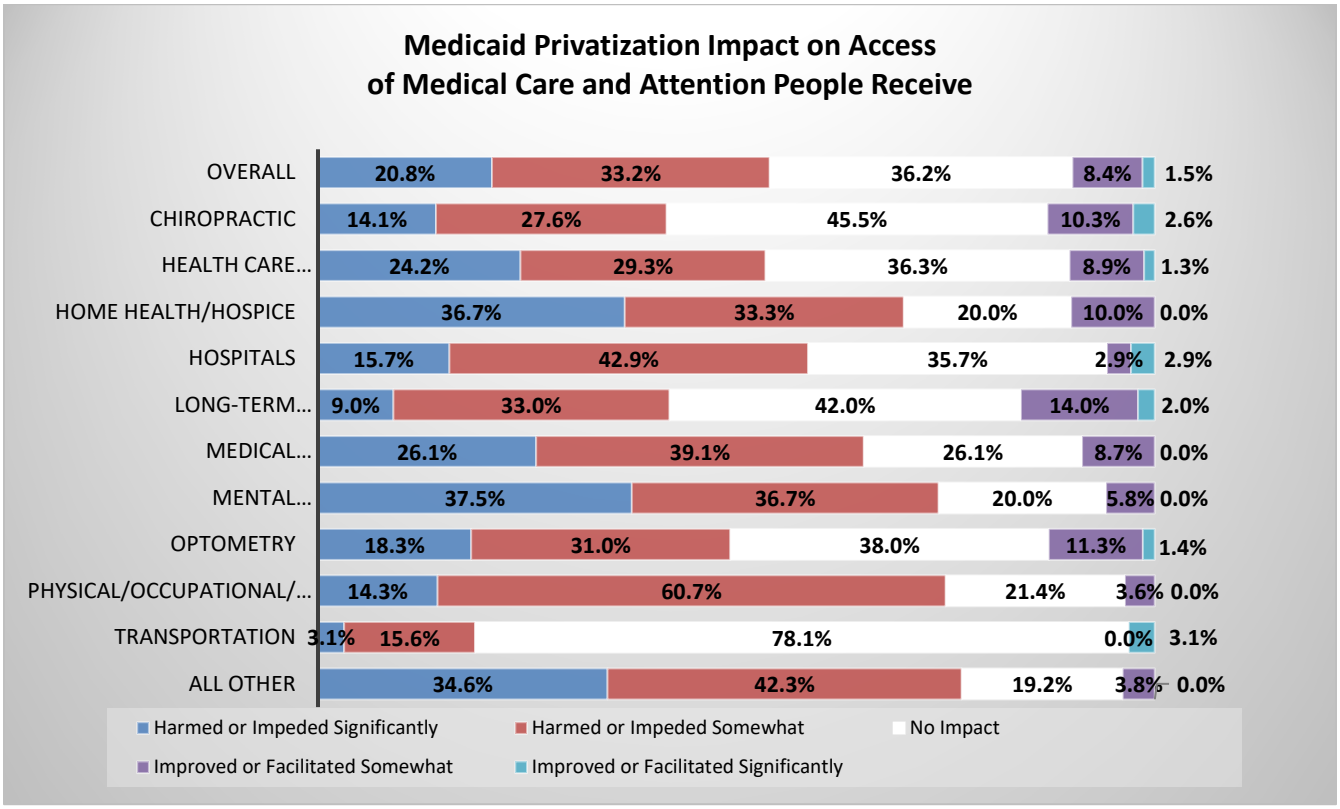


As illustrated by the **Table**, home health/hospice and mental health/substance abuse provider categories had the highest number of providers, at 70.0%, believing privatization of Medicaid has harmed or impeded somewhat or significantly the quality of care for members. However,

chiropractic had the highest number of providers, at 10.9%, reporting they believe privatization of Medicaid has improved or facilitated somewhat or significantly the quality of care for members. As stated earlier, home health/hospice providers were one of the provider categories believing the privatization of Medicaid has harmed or impeded the quality of care members, but they were also similar to the chiropractic category in that 10.0% of home health/hospice providers believed the privatization of Medicaid has improved or facilitated somewhat or significantly the quality of care for members.

Of all providers responding, 54.0% reported they believed the privatization of Medicaid has harmed or impeded somewhat or significantly member access to care, 36.2% believed there has been no impact, and 9.8% of the providers believed privatization has improved or facilitated somewhat or significantly the access to care for members. The breakdown of provider experience with the privatization of Medicaid and its impact on member access to care is summarized by provider category in **Table 26**.

Table 26



As illustrated by the **Table**, all other providers had the highest number of providers, at 76.9%, reporting they believe privatization of Medicaid has harmed or impeded somewhat or significantly the access to care for members. However, long-term care/dependent care had the highest number of providers, at 16.0%, reporting they believe privatization of Medicaid has improved or facilitated somewhat or significantly the access to care for members.

Surveyed Provider Other Comments

At the end of the survey, respondent providers were given the opportunity to provide any additional comments they believed should be communicated as part of the survey. We reviewed the information to determine the content of the responses and classify them into "general categories." In many instances, the provider responses included content that applied to several of the general categories. As a result, we classified the provider responses under as many of the general categories as indicated by the content.

During our review of the additional comments, we identified 19 general categories in which the provider responses could be classified as follows:

1. No or Incomplete Response or Unknown/Unsure – responses with no information provided, or where the response did not contain information sufficient to determine the content. As an example, a provider reported many of the survey questions were beyond the providers scope of knowledge.
2. Claims/Denial/Payment Difficulties with MCOs – provider responses included information concerning experienced inaccuracies, difficulties, denials, and other difficulties with claims, claim payments, or reductions in payments with the MCOs. As an example, a provider stated there is not a standard model under the MCO system for authorizations, claims coding, claims processing, and timeliness.
3. Communication Problems with MCOs – provider responses where the communication and/or customer service by the MCOs impacted the providers negatively in carrying out services or business operations. For example, a provider reported they never get the same answer twice when the provider calls the MCO with a problem and it takes them a long time to respond to problems.
4. Increased Provider Burden or Costs with MCOs – responses by providers that incurred an increase in costs to operate as a healthcare provider such as more time or resources to handle the requirements of the MCOs. For example, a provider reported in their experience, Medicaid privatization has delayed or impeded access to medical care, diverted time and resources that could have been spent on patient care to administration, and created financial hardships for providers causing cash flow slowdowns and decreasing already narrow operating margins.
5. MCO Administrative or Program Difficulties – responses included what providers believed to be negative programmatic or administrative polices or procedures with the MCO model. For example, a provider stated it is difficult to keep on top of what the Medicaid benefits are for each plan and right when the provider figures it out the MCO leaves and a new plan is introduced.
6. People or Medicaid Members Less Served with MCOs – responses by providers that believed people or Medicaid members were less served under the MCO model. For example, a provider believed providers in general have had to cut back on seeing/accepting Medicaid patients or providing services due to not getting paid or significant delay in receiving payments.
7. No Change – providers who did not see a change or difference between the fee-for-service or MCO model. As an example, a provider reported overall there have been pros and cons with the MCOs, but the provider didn't think these have greatly impacted the care patients received.
8. Positive Feedback FFS – any positive provider feedback specific to the FFS model. For example, a provider stated that for dual eligible nursing home residents the FFS model managed by the State of Iowa worked extremely well.
9. Negative Feedback FFS – any negative provider feedback specific to the FFS model. For example, a provider believed FFS limits patients.
10. Positive Feedback MCOs – any positive provider feedback specific to the MCO model. For example, a provider described manage care as being beneficial to their agency and the persons served. The provider was in a much better place financially which allowed for increased staff wages and benefits which had been frozen under FFS. This provider added the persons served have not been negatively impacted by managed care and although the transition was rough and somewhat stressful, the change to managed care has been positive.
11. Negative Feedback MCOs – any negative provider feedback specific to the MCO model. For example, a provider reported the change to the MCOS has some therapists thinking of leaving the business as it has had a profound negative impact on mental health services in general.

12. Positive Feedback Amerigroup – any positive provider feedback specific to the MCO Amerigroup. For example, a provider reported they have been impressed with the speed in which Amerigroup pays their claims and their responsiveness to provider questions.

13. Negative Feedback Amerigroup – any negative provider feedback specific to the MCO Amerigroup. For example, a provider reported at the time of the survey they had been waiting for approximately three months to become credentialed with Amerigroup.

14. Positive Feedback AmeriHealth – any positive provider feedback specific to the MCO AmeriHealth. For example, a provider reported AmeriHealth was on the right track as an MCO, but their departure caused this to end.

15. Negative Feedback AmeriHealth – any negative provider feedback specific to the MCO AmeriHealth. For example, a provider believed AmeriHealth was the most challenging and difficult MCO to work with.

16. Positive Feedback UnitedHealthcare – any positive provider feedback specific to the MCO UnitedHealthcare. For example, a provider described UnitedHealthcare as being very quick to pay.

17. Negative Feedback UnitedHealthcare – any negative provider feedback specific to the MCO UnitedHealthcare. For example, a provider reported UnitedHealthcare accepted and rejected claims randomly.

18. Positive Feedback Iowa Total Care – any positive provider feedback specific to the MCO Iowa Total Care. For example, a provider reported they do not accept any new Medicaid patients and are encouraging their existing Medicaid patients to switch to Iowa Total Care.

19. Negative Feedback Iowa Total Care – any negative provider feedback specific to the MCO Iowa Total Care. For example, a provider believed Iowa Total Care has been extremely difficult in handling claims/issue.

Schedule 14 summarizes additional comments which were provided by the different provider categories. As illustrated by the **Schedule**, the most common comments overall were no or incomplete response or unknown/unsure (41.8%). The other top other comments by the providers overall were claims/denials/payment difficulties (12.3%) and increased provider burden or costs with the MCOs (10.4%). The remaining categories of responses by the providers are listed in **Schedule 14**.

Conclusion

As previously stated, we decided to survey all of the hospitals in Iowa listed by the Iowa Hospital Association. Hospitals across Iowa are an integral part of their local healthcare systems. In some Iowa counties, the local hospital may be the only option for emergent, walk-in, and/or unscheduled health care services. Many hospitals in Iowa provide services across the continuum of care from primary care to long-term care. Because of their significant contributions to overall community well-being, they are a critical component of communities and changes such as the switch to a managed care system for Medicaid patients may have a significant impact on the services they can provide and the hospital's financial condition. Of the 120 hospitals we sent surveys to, 71 hospitals responded and, of those, 70 of the hospitals participated in both the FFS and MCO models when providing services to Medicaid eligible individuals.

Of the responses received from the hospitals, these were the most significant to the financial condition of the hospitals and their ability to continue providing a sufficient level of services to all individuals in their communities.

- Providers were asked to describe their satisfaction with MCOs regarding timely and accurate payments for services provided to Medicaid patients. As illustrated by **Table 4**, 48.6% of the hospitals responding reported they were extremely dissatisfied and 34.3%

were dissatisfied, for a total on 82.9% of responding hospitals. This was the highest level of dissatisfaction reported by any of the categories of the providers who responded.

- When the providers were asked to compare the MCO model to the FFS model regarding their reimbursement for services rendered to Medicaid members and, specifically, the settling of claims, 91.4% of the hospitals responded settling claims is a more complex process through MCOs. **Table 7** compares the hospitals' responses to other provider categories.
- When the providers were asked to compare the MCO model to the FFS model regarding the timely receipt of payment, 70% of the hospitals responded the MCOs pay in a less timely manner. **Table 8** compares the hospitals' responses to other provider categories.
- The providers surveyed were asked to compare the MCO model to the FFS model regarding the costs associated with staffing and administration. In order to determine costs associated with staffing and administration, providers were asked to describe costs associated with staffing and administration. **Table 9** illustrates 81.4% of hospitals responded costs increased. In addition, **Table 10** illustrates 75.7 % of the hospitals reported the amount they recognize as uncollectible fees and/or the amount of debt they have incurred has increased since the switch to the MCO model.
- **Table 20** illustrates just 2.9% of the hospitals reported they have decreased the number of Medicaid members served since moving to the MCO model and **Table 22** illustrates 98.6% of the hospitals reported they did not stop providing services to Medicaid members. However, **Table 24** illustrates 71.4% of the hospitals reported they have seen changes in the services denied to Medicaid members by MCOs.

These factors illustrate why 42.9% of the responding hospitals reported they were dissatisfied and 18.6% were extremely dissatisfied (for a total of 61.5%) when they were asked to describe their satisfaction with MCOs in terms of their ability to provides services to Medicaid patients. **Table 3** illustrates how the hospitals' responses compare to those of other provider categories. Based on the responses received to the survey, hospitals have continued to provide services, but the MCOs have increased the frequency of denied services. As a result, the hospitals bear the cost of the services which they have continued to provide.

As previously stated, hospitals across Iowa are an integral part of their local healthcare systems and, often, an integral part of local economies. In some Iowa counties, the local hospital may be the only option for emergent, walk-in, and/or unscheduled health care services and the largest employer. Because of their significant contributions to overall community well-being, they are a critical component of communities. Continuing to provide the medical services needed by community members for which they do not receive payment is not a viable ongoing business plan.

In addition to the information provided by hospitals in response to the survey, another comment provided during the survey is worthy of emphasis. When asked for information regarding experienced inaccuracies, difficulties, denials, or other challenges with claims, claim payments, or reductions in payment as a result of switching to the MCO model, providers responded there is not a standard model for authorizations, claims coding, claims processing, and timeliness. Each MCO sets its own standards in terms of what is / is not authorized, the services that require prior authorizations, claims coding, how claims are to be submitted for payment, and the deadlines for various scenarios associated with reporting services provided and ultimately receiving payment for those services. As a result, at times providers have had to be cognizant of the processes and requirements established by up to three MCOs at a given time and with requirements that change with each change in MCOs with which DHS/IME contract for managed care services. This compares to the single, long-standing process that had been in place under the FFS model.

As a result, DHS/IME should consider the viability of establishing a single set of policies, procedures, and requirements to be implement by all current and future MCOs with which contracts are established. The efficiencies to be gained can be realized by all providers and DHS/IME during their monitoring and oversight procedures

Report on a Survey of
Healthcare Providers
Comparing Medicaid's Managed Care Model
To the Fee-For Service Model

Schedules

Report on a Survey of Healthcare Providers
Comparing Medicaid's Managed Care Model to the Fee-For-Service Model

Managed Care Organization Benefits
For the period April 1, 2016 through July 1, 2019

General Categories	Chiropractic	Health Care Providers and Medical Clinics	Home Health and Hospice	Hospitals	Long-term and Dependent Care
No Benefit or None Identified	37.5%	52.1	52.8	36.1	67.9
More or Better Served Medicaid Population	13.5	15.0	5.6	21.6	3.6
Claims Processing or Payment Better/Faster	8.0	2.4	13.9	3.1	8.9
No or Incomplete Response	7.0	10.8	-	4.1	2.7
Better/ More Accessible Coverage/ Member Information/ Website/Customer Service	9.0	7.2	11.1	4.1	2.7
Increased Administrative Burden or Cost	4.0	3.0	2.8	13.4	1.8
Payment Inaccuracies/ Difficulties or Reduction	2.0	3.0	2.8	12.4	3.6
Money Savings or Less Government	1.0	3.6	-	2.1	0.9
No Change from FFS	4.0	0.6	-	-	0.9
Not Qualified or Unable to Respond	1.5	2.4	2.8	-	-
People or Medicaid Members Less Served	-	-	-	2.1	2.7
Positive Feedback Amerigroup	2.5	-	5.6	-	-
Negative Feedback Amerigroup	0.5	-	-	-	0.9
Positive Feedback AmeriHealth	1.0	-	-	1.0	0.9
Negative Feedback AmeriHealth	1.0	-	-	-	-
Negative Feedback UnitedHealthcare	1.0	-	-	-	0.9
Positive Feedback UnitedHealthcare	1.5	-	-	-	-
Positive Feedback Iowa Total Care	1.5	-	2.8	-	-
Negative Feedback Iowa Total Care	3.0	-	-	-	0.9

Provider Category (Percent):

Medical Equipment and Supplies	Mental Health and Substance Abuse	Optometry	Physical, Occupational and Speech Therapy	Transportation	All Other	Overall
56.0	38.1	36.7	61.8	40.0	62.1	46.1
-	14.2	12.7	2.9	5.7	-	11.8
8.0	7.7	20.3	5.9	20.0	10.3	8.3
16.0	6.5	8.9	11.8	20.0	-	7.3
4.0	8.4	11.4	-	5.7	10.3	7.1
8.0	5.8	1.3	5.9	-	3.4	4.5
4.0	5.8	1.3	2.9	-	6.9	4.1
-	1.9	-	-	2.9	-	1.5
4.0	0.6	2.5	-	2.9	-	1.5
-	1.3	-	2.9	2.9	6.9	1.4
-	1.9	3.8	-	-	-	1.1
-	1.3	1.3	-	-	-	1.0
-	2.5	-	-	-	-	0.6
-	1.3	-	-	-	-	0.6
-	-	-	-	-	-	0.2
-	1.3	-	-	-	-	0.5
-	-	-	-	-	-	0.3
-	-	-	2.9	-	-	0.5
-	2.5	-	2.9	-	-	1.2

Report on a Survey of Healthcare Providers
Comparing Medicaid's Managed Care Model to the Fee-For-Service Model

Managed Care Organization Disadvantages
For the period April 1, 2016 through July 1, 2019

General Categories	Chiropractic	Health Care Providers and Medical Clinics	Home Health and Hospice	Hospitals	Long-term and Dependent Care
Payment Inaccuracies/Difficulties or Reduction	15.4%	23.9	19.4	24.5	26.3
Increased Administrative Burden or Costs	19.9	22.8	17.2	19.7	19.6
Program/Administration Difficulties	8.6	12.1	12.9	16.3	14.2
Prior Authorization Difficulties	19.9	10.0	17.2	10.1	10.7
Communication/Customer Service Difficulties	5.5	8.3	16.1	14.4	16.0
People or Medicaid Members Less Served	6.2	6.9	15.1	9.1	8.5
No or Incomplete Response	5.1	5.9	1.1	1.4	0.7
No Disadvantage or None Identified/Unsure or No Change	4.5	4.5	-	-	1.1
Positive Feedback Amerigroup	-	0.7	-	-	-
Negative Feedback Amerigroup	1.7	2.1	1.1	3.8	2.1
Negative Feedback AmeriHealth	0.7	0.3	-	-	-
Positive Feedback UnitedHealthcare	-	-	-	-	-
Negative Feedback UnitedHealthcare	1.7	-	-	-	-
Positive Feedback Iowa Total Care	-	-	-	-	-
Negative Feedback Iowa Total Care	11.0	2.4	-	0.5	0.7

Provider Category (Percent):

Medical Equipment and Supplies	Mental Health and Substance Abuse	Optometry	Physical, Occupational and Speech Therapy	Transportation	All Other	Overall
24.4	23.2	25.2	16.7	28.6	21.6	22.5
13.3	20.7	15.0	14.8	9.5	23.5	19.5
15.6	12.7	23.4	7.4	14.3	15.7	13.3
17.8	4.7	0.9	18.5	-	9.8	11.0
6.7	12.3	6.5	7.4	9.5	11.8	10.8
6.7	10.1	4.7	14.8	2.4	7.8	8.3
6.7	2.5	11.2	11.1	11.9	-	4.1
2.2	1.8	7.5	7.4	19.0	-	3.2
-	0.7	-	-	-	-	0.2
2.2	5.1	-	1.9	2.4	2.0	2.5
-	0.4	0.9	-	-	2.0	0.3
-	0.4	-	-	-	-	0.1
-	1.8	0.9	-	-	2.0	0.7
-	0.4	-	-	-	-	0.1
4.4	3.3	3.7	-	2.4	3.9	3.5

Report on a Survey of Healthcare Providers
Comparing Medicaid's Managed Care Model to the Fee-For-Service Model

Fee-for-Service Benefits
For the period April 1, 2016 through July 1, 2019

General Categories	Chiropractic	Health Care Providers and Medical Clinics	Home Health and Hospice	Hospitals	Long-term and Dependent Care
Better Program/ Administration	27.9%	34.6	22.6	33.3	25.3
Claims Processing/ Payment Better	16.8	20.4	25.8	24.6	34.8
More or Better Served Medicaid Population	7.3	8.5	12.9	8.0	9.6
No Benefit or None Identified or Unsure	14.5	9.0	3.2	-	3.9
Fewer Administrative Burdens/Costs	6.7	7.1	12.9	10.9	10.1
No or Incomplete Response	11.7	8.1	-	4.3	2.8
Fewer Prior Authorization Issues	6.7	7.1	14.5	10.1	2.8
Denials Fewer/Simpler	1.7	3.8	4.8	8.7	10.1
No Change from MCO	5.6	0.9	1.6	-	0.6
Not Qualified or Unable to Respond	1.1	0.5	1.6	-	-
Increased Administrative Burden or Costs	-	-	-	-	-

Provider Category (Percent):						
Medical Equipment and Supplies	**Mental Health and Substance Abuse**	**Optometry**	**Physical, Occupational and Speech Therapy**	**Transportation**	**All Other**	**Overall**
39.4	35.8	29.5	20.5	33.3	34.2	30.8
24.2	21.8	26.1	13.6	12.1	31.6	23.4
9.1	12.8	8.0	6.8	6.1	10.5	9.2
3.0	8.9	17.0	11.4	27.3	7.9	8.7
6.1	6.7	5.7	13.6	3.0	5.3	8.1
9.1	5.0	11.4	11.4	12.1	2.6	6.8
6.1	4.5	1.1	18.2	-	5.3	6.4
3.0	1.1	1.1	2.3	-	-	4.1
-	-	-	-	3.0	-	1.3
-	3.4	-	2.3	-	2.6	1.0
-	-	-	-	3.0	-	0.1

Report on a Survey of Healthcare Providers
Comparing Medicaid's Managed Care Model to the Fee-For-Service Model

Fee-for-Service Disadvantages
For the period April 1, 2016 through July 1, 2019

General Categories	Chiropractic	Health Care Providers and Medical Clinics	Home Health and Hospice	Hospitals	Long-term and Dependent Care
No Disadvantages or None Identified/Unsure or No Change	42.0%	36.1	62.5	43.1	67.3
Program/Administration Difficulties	17.9	18.1	21.9	15.3	11.9
No or Incomplete Response	19.8	21.7	3.1	15.3	9.9
Payment Inaccuracies/Difficulties or Reduction	11.7	12.7	3.1	20.8	7.9
People or Medicaid Members Less Served	3.7	6.0	6.3	4.2	1.0
Increased Administrative Burden or Costs	2.5	3.6	3.1	-	2.0
Not Qualified or Unable to Respond	2.5	1.8	-	1.4	-

Provider Category (Percent):						
Medical Equipment and Supplies	**Mental Health and Substance Abuse**	**Optometry**	**Physical, Occupational and Speech Therapy**	**Transportation**	**All Other**	**Overall**
41.7	42.6	36.1	36.7	33.3	50.0	44.0
16.7	17.8	29.2	16.7	11.1	23.1	17.9
20.8	14.7	20.8	23.3	19.4	7.7	17.1
16.7	13.2	13.9	16.7	25.0	15.4	13.3
-	4.7	-	-	2.8	-	3.4
4.2	1.6	-	6.7	8.3	-	2.5
-	5.4	-	-	-	3.8	1.9

Report on a Survey of Healthcare Providers
Comparing Medicaid's Managed Care Model to the Fee-For-Service Model

Financial Impact of Fee-for-Service on Providers
For the period April 1, 2016 through July 1, 2019

General Categories	Chiropractic	Health Care Providers and Medical Clinics	Home Health and Hospice	Hospitals	Long-term and Dependent Care
Did Not Experience a Financial Impact	78.8%	62.4	83.3	68.6	80.0
Did Experience a Financial Impact (See detail below)	21.2	37.6	16.7	31.4	20.0
Financial Impact Detail:					
Claims Not Paid/Decline in Revenue	42.3	54.2	42.9	53.1	27.5
Increased Administrative Burden or Costs	25.0	13.9	28.6	25.0	35.0
Payment Delays	5.8	16.7	28.6	15.6	30.0
No or Incomplete Response	3.8	8.3	-	3.1	-
Negative Feedback Amerigroup	5.8	1.4	-	3.1	2.5
Negative Feedback Iowa Total Care	5.8	2.8	-	-	2.5
Negative Feedback UnitedHealthcare	5.8	-	-	-	-
Negative Feedback AmeriHealth	5.8	1.4	-	-	2.5
Positive Feedback Iowa Total Care	-	1.4	-	-	-

Provider Category (Percent):						
Medical Equipment and Supplies	**Mental Health and Substance Abuse**	**Optometry**	**Physical, Occupational and Speech Therapy**	**Transportation**	**All Other**	**Overall**
73.9	71.7	90.1	75.0	62.5	53.8	73.3
26.1	28.3	9.9	25.0	37.5	46.2	26.7
25.0	33.9	50.0	38.5	66.7	26.3	42.5
62.5	25.4	-	30.8	13.3	26.3	24.0
12.5	15.3	12.5	15.4	6.7	15.8	15.7
-	8.5	25.0	7.7	13.3	10.5	6.5
-	3.4	-	7.7	-	10.5	3.4
-	6.8	-	-	-	-	3.1
-	5.1	-	-	-	10.5	2.5
-	1.7	12.5	-	-	-	2.2
-	-	-	-	-	-	0.3

Report on a Survey of Healthcare Providers
Comparing Medicaid's Managed Care Model to the Fee-For-Service Model

Financial Impact of MCOs on Providers
For the period April 1, 2016 through July 1, 2019

General Categories	Chiropractic	Health Care Providers and Medical Clinics	Home Health and Hospice	Hospitals	Long-term and Dependent Care
Did Not Experience a Financial Impact	69.9%	43.3	26.7	45.7	30.0
Did Experience a Financial Impact (See detail below)	30.1	56.7	73.3	54.3	70.0
Financial Impact Detail:					
Claims Not Paid/Decline in Revenue	37.5	41.0	33.3	43.9	28.1
Increased Administrative Burden or Costs	17.5	15.6	31.0	31.6	39.5
Payment Delays	6.3	8.2	16.7	7.0	27.2
No or Incomplete Response	5.0	19.7	-	7.0	1.8
Negative Feedback Iowa Total Care	8.8	6.6	4.8	3.5	1.8
Prior Authorization Issues/Delays	7.5	1.6	9.5	3.5	0.9
Negative Feedback UnitedHealthcare	6.3	4.1	2.4	1.8	-
Negative Feedback Amerigroup	3.8	1.6	2.4	1.8	-
Negative Feedback AmeriHealth	7.5	1.6	-	-	0.9

Provider Category (Percent):						
Medical Equipment and Supplies	**Mental Health and Substance Abuse**	**Optometry**	**Physical, Occupational and Speech Therapy**	**Transportation**	**All Other**	**Overall**
56.5	32.5	70.4	60.7	59.4	30.8	48.3
43.5	67.5	29.6	39.3	40.6	69.2	51.7
27.3	34.8	60.0	36.4	50.0	50.0	37.7
31.8	27.8	26.7	27.3	20.0	19.2	26.4
22.7	15.2	3.3	4.5	10.0	3.8	13.1
-	3.2	-	13.6	10.0	15.4	6.9
4.5	10.1	3.3	4.5	-	-	5.8
13.6	1.3	3.3	4.5	5.0	-	3.3
-	3.2	-	-	5.0	7.7	2.9
-	3.2	-	9.1	-	3.8	2.2
-	1.3	3.3	-	-	-	1.7

Report on a Survey of Healthcare Providers
Comparing Medicaid's Managed Care Model to the Fee-For-Service Model

Debt Incurred due to Switch from FFS to MCOs
For the period April 1, 2016 through July 1, 2019

General Categories	Chiropractic	Health Care Providers and Medical Clinics	Home Health and Hospice	Hospitals	Long-term and Dependent Care
Did Not Incur Debt or Loans	92.9%	87.3	66.7	97.1	73.0
Did Incur Debt or Loans (See detail below)	7.1	12.7	33.3	2.9	27.0
Incurred Debt or Loans Detail:					
Business Loan/LOC/Debt	41.7	29.2	33.3	20.0	46.8
Claims not Paid/are Delayed or Lower Reimbursement	25.0	50.0	33.3	40.0	40.4
Other Funding Sources Used	16.7	8.3	13.3	-	2.1
Difficulty with Payroll	-	-	6.7	20.0	6.4
No or Incomplete Response or Unsure	8.3	12.5	-	-	2.1
Difficulty/Late to Pay Bills or Incurred Late Fees or Interest	8.3	-	13.3	20.0	2.1

Provider Category (Percent):

Medical Equipment and Supplies	Mental Health and Substance Abuse	Optometry	Physical, Occupational and Speech Therapy	Transportation	All Other	Overall
95.7	73.3	97.2	92.9	96.9	80.8	86.1
4.3	26.7	2.8	7.1	3.1	19.2	13.9
100.0	38.3	-	50.0	-	37.5	38.0
-	19.1	-	-	50.0	25.0	31.9
-	19.1	33.3	-	50.0	25.0	12.0
-	10.6	33.3	-	-	12.5	7.2
-	8.5	33.3	50.0	-	-	6.6
-	4.3	-	-	-	-	4.2

Report on a Survey of Healthcare Providers
Comparing Medicaid's Managed Care Model to the Fee-For-Service Model

Provider Services to Medicaid Members
For the period April 1, 2016 through July 1, 2019

General Categories	Chiropractic	Health Care Providers and Medical Clinics	Home Health and Hospice	Hospitals	Long-term and Dependent Care
Did Not Stop Providing Services to Medicaid Members	95.5%	93.0	96.7	98.6	100.0
Did Stop Providing Services to Medicaid Members (See reasons below)	4.5	7.0	3.3	1.4	-
Reasons Stopped Providing Service:					
Unable to Financially Sustain	28.6	54.5	100.0	-	-
Unable to Comply with Contract Terms	-	-	-	100.0	-
Other (See Below Specific Detail):	71.4	45.5	-	-	-
Other - Specific Detail:					
Increased Administrative Burden or Costs	40.0	40.0	-	-	-
Provider Application/ Credentialing Issues	60.0	-	-	-	-
Payment Difficulties/ Low Reimbursement	-	40.0	-	-	-
Closed/Retired	-	-	-	-	-
Prior Authorization Issues	-	-	-	-	-
No Response	-	20.0	-	-	-

Provider Category (Percent):

Medical Equipment and Supplies	Mental Health and Substance Abuse	Optometry	Physical, Occupational and Speech Therapy	Transportation	All Other	Overall
100.0	91.7	95.8	75.0	100.0	73.1	94.2
-	8.3	4.2	25.0	-	26.9	5.8
-	40.0	-	57.1	-	42.9	42.6
-	30.0	-	-	-	-	8.5
-	30.0	100.0	42.9	-	57.1	48.9
-	33.3	33.3	33.3	-	25.0	34.8
-	33.3	66.7	-	-	25.0	30.4
-	33.3	-	-	-	-	13.0
-	-	-	33.3	-	25.0	8.7
-	-	-	33.3	-	25.0	8.7
-	-	-	-	-	-	4.3

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Costs Incurred by Providers
For the period April 1, 2016 through July 1, 2019

	Changed Costs Due to the Privatization of Providers that Responded (Percent):			
Provider Category	**No or Incomplete Response or Unknown/Unsure**	**Zero or No Costs Incurred**	**Other Cost Amount Incurred**	**Single, Annual or Monthly Cost Amount Incurred**
Overall (Total)	99.1%	0.2	0.1	0.5
Chiropractic	98.1	-	0.6	1.3
Health Care Providers/Medical Clinics	100	-	-	-
Home Health/Hospice	100	-	-	-
Hospitals	100	-	-	-
Long-term Care/Dependent Care	100	-	-	-
Medical Equipment/Supplies	100	-	-	-
Mental Health/Substance Abuse	99.2	0.8	-	-
Optometry	98.6	1.4	-	-
Physical/Occupational/Speech Therapy	100	-	-	-
Transportation	100	-	-	-
All Other	92.3	-	0	7.7

Medicaid-Medical Staff

Amount of Single, Annual, or Monthly Cost:		
Single	**Annual**	**Monthly**
$4,400.00	95,000.00	-
3,000.00	5,000.00	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
1,400.00	90,000.00	-

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Provider Costs for Administrative Staff
For the period April 1, 2016 through July 1, 2019

	Changed Costs Due to the Privatization of Providers that Responded (Percent):			
Provider Category	**No or Incomplete Response or Unknown/Unsure**	**Zero or No Costs Incurred**	**Other Cost Amount Incurred**	**Single, Annual or Monthly Cost Amount Incurred**
Overall (Total)	58.8%	15.4	4.7	21.2
Chiropractic	51.3	30.1	6.4	12.2
Health Care Providers/Medical Clinics	74.5	9.6	3.2	12.7
Home Health/Hospice	53.3	6.7	10	30
Hospitals	41.4	7.1	1.4	50
Long-term Care/Dependent Care	46	10	1	43
Medical Equipment/Supplies	56.5	21.7	0	21.7
Mental Health/Substance Abuse	66.7	10	5	18.3
Optometry	57.7	21.1	8.5	12.7
Physical/Occupational/Speech Therapy	78.6	7.1	10.7	3.6
Transportation	62.5	25	6.3	6.3
All Other	53.8	15.4	3.8	26.9

Medicaid-Administrative Staff

Amount of Single, Annual, or Monthly Cost:

Single	Annual	Monthly
$14,810,938.00	4,253,929.00	14,265.00
49,900.00	5,680.00	3,665.00
3,910,400.00	51,000.00	500.00
105,000.00	1,347,000.00	-
6,853,126.00	1,460,085.00	-
2,212,810.00	757,964.00	5,900.00
119,000.00	75,000.00	-
1,028,000.00	333,000.00	4,000.00
105,000.00	23,000.00	200.00
-	31,200.00	-
30,500.00	-	-
397,202.00	170,000.00	-

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Provider Write Offs
For the period April 1, 2016 through July 1, 2019

	Changed Costs Due to the Privatization of Providers that Responded (Percent):			
Provider Category	**No or Incomplete Response or Unknown/Unsure**	**Zero or No Costs Incurred**	**Other Cost Amount Incurred**	**Single, Annual or Monthly Cost Amount Incurred**
Overall (Total)	59.8%	13.7	5	21.5
Chiropractic	55.1	18.6	9	17.3
Health Care Providers/Medical Clinics	73.9	7.6	1.9	16.6
Home Health/Hospice	53.3	6.7	6.7	33.3
Hospitals	51.4	12.9	0	35.7
Long-term Care/Dependent Care	48	9	10	33
Medical Equipment/Supplies	65.2	17.4	0	17.4
Mental Health/Substance Abuse	62.5	12.5	1.7	23.3
Optometry	60.6	19.7	5.6	14.1
Physical/Occupational/Speech Therapy	75	7.1	14.3	3.6
Transportation	56.3	31.3	0	12.5
All Other	46.2	19.2	7.7	26.9

Medicaid-Write-offs for Uncollectible Fees

Amount of Single, Annual, or Monthly Cost:		
Single	**Annual**	**Monthly**
$ 22,687,772.52	16,106,250.00	5,600.00
164,775.00	17,000.00	600.00
3,537,500.00	2,051,000.00	2,500.00
572,500.00	450,000.00	-
12,502,123.70	12,925,000.00	-
2,061,407.82	450,000.00	-
174,967.00	60,000.00	-
2,998,574.00	102,000.00	2,000.00
416,000.00	40,000.00	500.00
38,000.00	-	-
63,000.00	11,250.00	-
158,925.00	-	-

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Additional Equipment by Providers
For the period April 1, 2016 through July 1, 2019

	Changed Costs Due to the Privatization of Providers that Responded (Percent):			
Provider Category	**No or Incomplete Response or Unknown/Unsure**	**Zero or No Costs Incurred**	**Other Cost Amount Incurred**	**Single, Annual or Monthly Cost Amount Incurred**
Overall (Total)	53.8%	31.4	0.6	14.3
Chiropractic	42.3	46.8	0.6	10.3
Health Care Providers/Medical Clinics	72	21.7	0	6.4
Home Health/Hospice	53.3	33.3	0	13.3
Hospitals	42.9	34.3	0	22.9
Long-term Care/Dependent Care	39	25	1	35
Medical Equipment/Supplies	65.2	26.1	0	8.7
Mental Health/Substance Abuse	56.7	29.2	0.8	13.3
Optometry	54.9	32.4	1.4	11.3
Physical/Occupational/Speech Therapy	71.4	21.4	3.6	3.6
Transportation	53.1	37.5	0	9.4
All Other	53.8	26.9	0	19.2

Medicaid-Write-offs for Additional Equipment

Amount of Single, Annual, or Monthly Cost:

Single	Annual	Monthly
$ 4,245,745.00	9,500.00	158,600.00
27,335.00	3,000.00	-
2,406,300.00	-	-
40,000.00	-	300.00
605,500.00	-	-
343,000.00	5,000.00	156,700.00
8,000.00	1,500.00	-
241,250.00	-	1,000.00
168,350.00	-	-
1,000.00	-	-
7,500.00	-	-
397,510.00	-	-

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Changes in Services by Providers
For the period April 1, 2016 through July 1, 2019

General Categories	Chiropractic	Health Care Providers and Medical Clinics	Home Health and Hospice	Hospitals	Long-term and Dependent Care
MCO Coverage Issues/Less Coverage	39.5%	30.8	50.0	30.8	26.7
MCO Preauthorization Issues/Burdensome Requirements	21.1	16.9	10.0	17.3	50.0
MCO Payment Issues/Denials/Less Reimbursement	5.3	13.8	20.0	11.5	10.0
No or Incomplete Response or Unknown/Unsure	2.6	21.5	-	11.5	3.3
Negative Feedback Amerigroup	13.2	7.7	-	19.2	-
Patients Less Served under MCOs	-	-	20.0	5.8	3.3
Negative Feedback Iowa Total Care	10.5	4.6	-	1.9	-
MCO Better Coverage/ Reimbursement	7.9	1.5	-	1.9	-
MCO Provider Enrollment Issues	-	1.5	-	-	3.3
Positive Feedback Iowa Total Care	-	1.5	-	-	-
Negative Feedback UnitedHealthcare	-	-	-	-	3.3

Provider Category (Percent):						
Medical Equipment and Supplies	**Mental Health and Substance Abuse**	**Optometry**	**Physical, Occupational and Speech Therapy**	**Transportation**	**All Other**	**Overall**
35.7	36.7	41.0	28.6	40.0	37.5	34.6
35.7	25.0	5.1	28.6	20.0	12.5	21.5
14.3	13.3	15.4	7.1	40.0	12.5	12.5
14.3	6.7	15.4	-	-	25.0	10.7
-	10.0	2.6	7.1	-	-	8.4
-	6.7	7.7	14.3	-	12.5	4.8
-	-	7.7	7.1	-	-	3.6
-	-	2.6	-	-	-	1.8
-	-	-	7.1	-	-	0.9
-	-	2.6	-	-	-	0.6
-	1.7	-	-	-	-	0.6

Report on a Survey of Healthcare Providers
Comparing Medicaid's Managed Care Model to the Fee-For-Service Model

Other Comments by Providers
For the period April 1, 2016 through July 1, 2019

General Categories	Chiropractic	Health Care Providers and Medical Clinics	Home Health and Hospice	Hospitals	Long-term and Dependent Care
No or Incomplete Response or Unknown/Unsure	50.5%	59.4	32.0	29.1	20.3
Claims/Denial/Payment Difficulties with MCOs	7.3	9.1	14.0	12.8	21.2
Increased Provider Burden or Costs with MCOs	8.7	6.6	16.0	13.5	16.0
Negative Feedback MCOs	6.0	6.6	14.0	4.7	15.6
People or Members Less Served with MCOs	4.1	7.1	6.0	3.4	8.5
MCO Administrative or Program Difficulties	6.0	2.5	10.0	0.7	7.1
Communication Problems with MCOs	2.8	1.5	2.0	6.8	1.9
Negative Feedback Iowa Total Care	5.0	3.0	2.0	6.1	2.8
Negative Feedback Amerigroup	1.4	1.0	2.0	5.4	1.4
Negative Feedback UnitedHealthcare	1.8	0.5	-	5.4	0.5
Negative Feedback AmeriHealth	0.9	-	-	5.4	0.9
Amerigroup Positive	0.9	0.5	-	0.7	-
Positive Feedback FFS	0.9	0.5	-	0.7	0.9
Positive Feedback MCOs	0.5	-	-	-	1.4
No Change	1.8	0.5	-	-	-
Positive Feedback Iowa Total Care	-	-	-	-	-
Positive Feedback AmeriHealth	-	-	-	-	-
Negative Feedback FFS	-	-	-	-	-
Positive Feedback UnitedHealthcare	-	-	-	-	-

Provider Category (Percent):						
Medical Equipment and Supplies	**Mental Health and Substance Abuse**	**Optometry**	**Physical, Occupational and Speech Therapy**	**Transportation**	**All Other**	**Overall**
28.1	38.2	61.2	58.3	57.5	36.8	41.8
21.9	10.6	4.7	8.3	15.0	21.1	12.3
6.3	9.5	4.7	11.1	5.0	13.2	10.4
12.5	9.5	8.2	2.8	-	5.3	8.4
6.3	8.0	5.9	-	5.0	5.3	6.1
6.3	3.0	3.5	8.3	7.5	10.5	4.8
3.1	5.0	3.5	5.6	2.5	5.3	3.4
6.3	3.5	-	-	-	2.6	3.4
3.1	3.0	1.2	2.8	2.5	-	2.2
-	0.5	1.2	-	-	-	1.3
-	1.0	1.2	-	-	-	1.2
-	2.0	-	-	-	-	0.6
-	-	-	-	2.5	-	0.6
3.1	-	2.4	-	-	-	0.6
-	-	-	-	-	-	0.4
-	1.5	1.2	-	-	-	0.3
-	0.5	-	-	-	-	0.1
-	0.5	-	-	-	-	0.1
-	0.5	-	-	-	-	0.1

Report on a Survey of
Healthcare Providers
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To the Fee-For-Service Model

Staff

This performance audit was conducted by:

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