

Medical Assistance

Medicaid - Title XIX



Purpose

Medical Assistance (Medicaid—Title XIX) provides medically necessary health care coverage for financially needy adults, children, parents with children, people with disabilities, elderly people and pregnant women. The goal is for members to live healthy, stable and self-sufficient lives.

Effective April 1, 2016, Medicaid Modernization is a major initiative in which the Iowa Department of Human Services (DHS) has enrolled the majority of the Medicaid members in managed care organizations (MCOs), Children’s Health Insurance Plan (CHIP), Healthy and Well Kids in Iowa (*hawk-i*) and Iowa Health and Wellness Plan members are also enrolled in MCOs). DHS has contracted with MCOs to provide comprehensive health care services including physical health, behavioral health and long term supports and services. This single system of care promotes the delivery of efficient, coordinated and high quality health care and establishes accountability in health care coordination.

IA Health Link is the name and brand for the new managed care program. The IA Health Link name and logo represents the connection between physical health, behavioral health, and long term care. It previously represented the Iowa Health and Wellness Plan and was designed for subsequent Medicaid transitions. Using the IA Health Link branding to represent the managed care program supports the state’s efforts to ensure a successful transition.

Who Is Helped

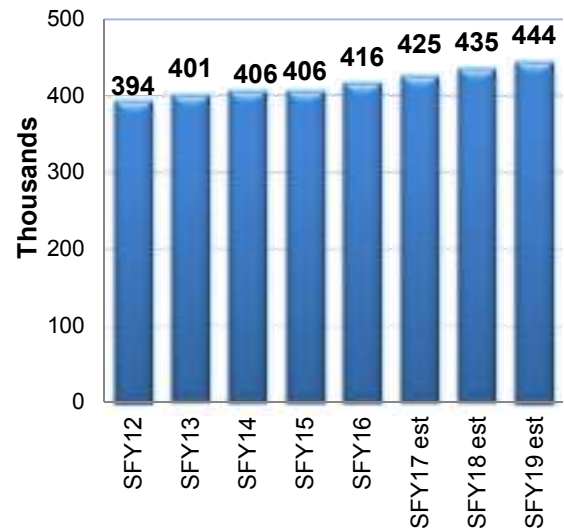
Medicaid is projected to serve nearly 770,000 Iowans (unduplicated) or 24.0 percent of Iowa’s population in SFY17 and over 795,000 (unduplicated) or 25.7 percent of Iowa’s population by SFY19.

- Medicaid is Iowa’s second largest health care payer, processing nearly 32 million claims in SFY16 (10 percent decrease from SFY15).

Traditional Medicaid eligibility is based on a combination of income and other criteria that must be met.

- Members must meet certain income criteria based on multiple eligibility standards and be a U.S. citizen or a legal qualified non-citizen. Citizenship status is verified through the Social Security Administration and legal non-citizens must provide original documentation to verify their status.
- Generally, Medicaid covers low-income members who are aged (over age 65), blind, disabled, pregnant women, children (under 21 years of age), or members of a family with children.

Average Regular Medicaid Enrollment*

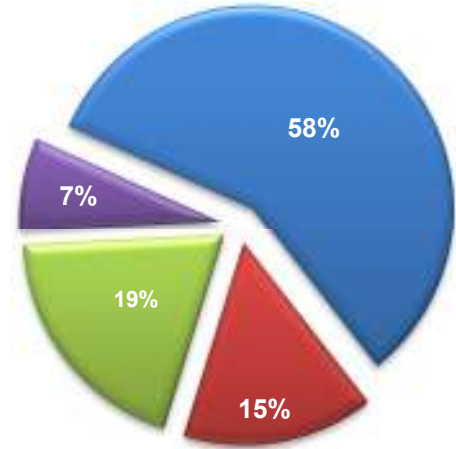


*Note: Excludes Health and Wellness Plan and Family Planning Waiver

- Medicaid is not available to individuals considered to be inmates of public, non-medical institutions except for inpatient hospital care provided off the grounds of the jail/prison under certain circumstances. Persons who are on probation or are paroled are not considered inmates. Persons who are on work release are considered to be inmates.
- The most common Medicaid member is, on average, a 9-year old child who is very healthy and uses very few health care services apart from well-child care, immunizations, and treatment for common childhood illnesses, such as ear infections. Medicaid covers thousands of such children for very minimal cost.
- Additional populations served include:
 - Individuals with income over 133 percent of the Federal Poverty Level (FPL) through the Family Planning Waiver. This program provides very limited covered services.
 - Medicare populations, where Medicaid covers the cost of Medicare premiums, deductibles, and co-payments (Qualified Medicare Beneficiaries).
- The Iowa Health and Wellness Plan was enacted through bi-partisan legislation to provide comprehensive health coverage to low income adults. The plan offers coverage to adults age 19-64 with an income up to 133 percent of the FPL (\$15,800 per year for a family of one in 2016). The plan began on January 1, 2014, and currently serves more than 135,000 Iowans.
 - The Iowa Wellness Plan covers adults ages 19 to 64 with incomes at or below 100 of FPL (\$11,880 for individuals or \$16,020 for a family of two in 2016). Prior to April 1, 2016, members were able to choose a provider from the statewide Medicaid provider network and get care from local providers.

Average Regular Medicaid Enrollment SFY16: 416,285*

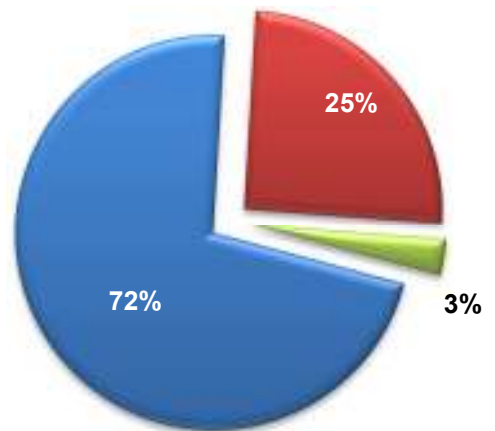
- Child (58%)
- Adult (15%)
- Disabled (19%)
- Elderly (7%)



*Note: Excludes Health and Wellness Plan and Family Planning Waiver

Ending Medicaid Enrollment SFY16

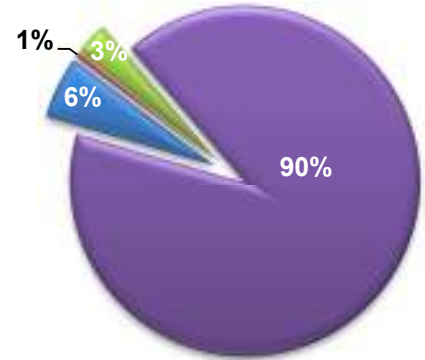
- Regular Medicaid (72%)
- Iowa Health and Wellness Plan (25%)
- Family Planning Waiver (3%)



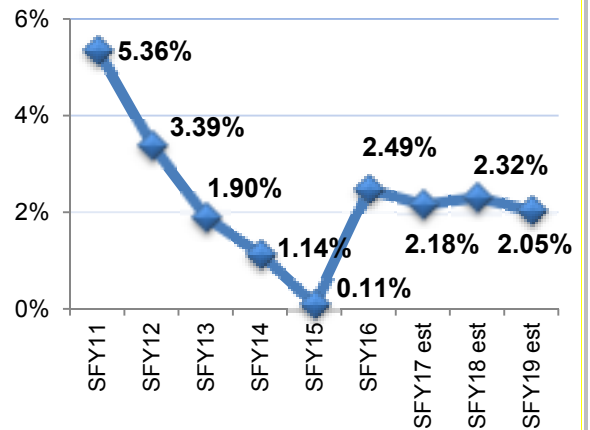
- Enrollment growth is increasing.**
 There were 416,285 members enrolled in regular Medicaid in SFY16, a growth of 2.5 percent from SFY15. Growth has increased from 0.1 percent in SFY15 and 1.14 percent in SFY14. Excluding the Iowa Health and Wellness Plan, enrollment growth is projected to increase by 2.3 percent in SFY18 and 2.1 percent in SFY19.
- Of those newly enrolled, the largest growth in recent years has been with children. In SFY13 growth was 2.43 percent, in SFY14, growth fell to 0.91 percent, in SFY15, enrollment declined by 0.48 percent. Enrollment grew in SFY16 by 3.62 percent. Growth for SFY17-19 is projected to be 2.87 percent in SFY17, 2.86 in SFY18, and 2.43 percent in SFY19.
- Medicaid plays a key role in the state's child welfare system by funding health care for children in state care. Medicaid provides coverage to children in subsidized adoptive homes, thereby making permanent placement more accessible for children who cannot return to their birth families.

Members by Setting SFY16

- HCBS Waivers (23,839)
- ICF/ID (1,800)
- NF (12,668)
- Home (377,978)



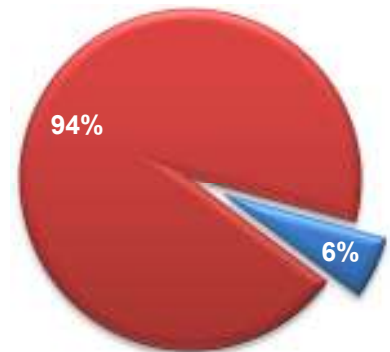
Medicaid Enrollment Change



*Note: Excludes Health and Wellness Plan and Family Planning Waiver

Estimated Enrollment Fee-for-Service v Managed Care*

- Fee-for-Service 6%
- Managed Care Organization 94%



*Regular Medicaid

- ✓ Since SFY10, children have accounted for 66 percent of Medicaid growth.
- ✓ Medicaid serves adults with serious and persistent mental illness (such as schizophrenia or bipolar disorder) and children with Serious Emotional Disturbance. Studies show that adults with serious mental illness live 25 years less than adults without this condition.
- ✓ Medicaid serves elderly persons who are low-income and very frail. The typical long term care member for older lowans (65 and older) is a 72 year-old female who needs assistance with at least one activity of daily living, such as personal care.
- ✓ Medicaid serves individuals with both physical and/or intellectual disabilities. The typical member with a disability accessing long term care services is a 28 year-old male with an intellectual disability and needs supports with life skills.
- ✓ Medicaid members currently have access to the Program for All-Inclusive Care for the Elderly (PACE) in three service areas, covering 16 counties across the state.

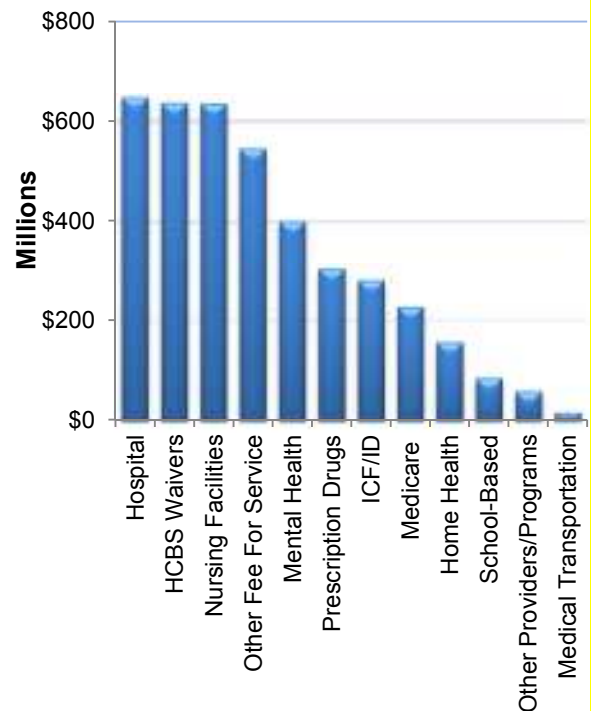
Services

Medicaid covers a comprehensive range of health care services for lowans who meet the program's eligibility criteria

April 1, 2016, the majority of members began having their services coordinated through a managed care entity, with the exceptions of the Health Insurance Premium Payment (HIPP) program, Medically Needy, PACE enrollees, as well as American Indian, Alaskan natives or that participate in the Medicare Savings Program.

- **Physical Health Care Services** include physician care, hospital services, labs, prescription drugs, home health care, rural health clinic (RHC) services, Federally Qualified Health Centers (FQHCs) services, chiropractic care, physical therapy, and dental care.
- **Behavioral Care Services** include community mental health services, hospital services, physician care, psychiatric medical institution care, outpatient treatment and therapy, rehabilitative mental health services (known as Behavioral Health Intervention Services), as well as non-traditional services such as peer support and Assertive Community Treatment, and substance abuse treatment.
- **Long-Term Care Services** include nursing home care, Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID), and home and community based services (HCBS) that allows individuals to remain in their homes.

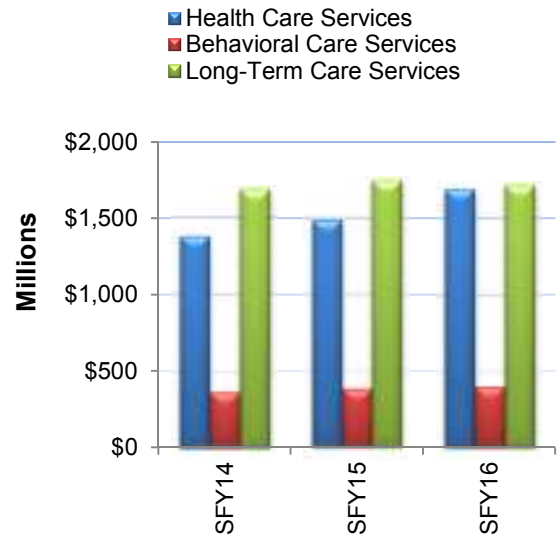
SFY16 Medicaid Expenditures by Provider Type \$4.0 Billion*



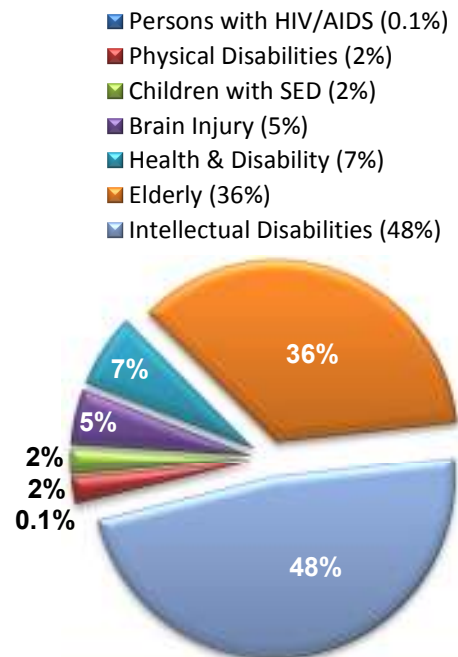
*Note: annualized FFS data and excludes Iowa Health and Wellness Plan

- **Home and Community Based Services (HCBS)** are for people with disabilities and older lowans who need services to allow them to stay in their home and community with services. The program names are HCBS Waivers (there are seven), Habilitation Services, Program of All-Inclusive Care for the Elderly (PACE), Home Health, Hospice, Targeted Case management (TCM), and Money Follows the person (MFP). These programs include services such as employment, residential, home health, assistance with personal care, homemaking and respite care that are intended to assist members with remaining in their homes and communities.
- Members will continue to have access to the same menu of services under managed care as they do during the first third of SFY16.
- **HCBS Services** are delivered through seven 1915(c) waivers that are targeted to specific populations including persons who:
 - Are Elderly
 - Have an Intellectual Disability
 - Have a Disability (two waivers)
 - Physical
 - Other Disabilities
 - Are Children with Serious Emotional Disturbance
 - Are Living with HIV/AIDS
 - Have a Brain Injury

Reguarl Medicaid Spending by Category



SFY16 HCBS Waiver Members



- ✓ *Based on fee-for-service experience, the average cost of a member in a nursing facility is \$48,869 per year, versus \$11,641 for a person served through an HCBS waiver.*
- ✓ *Based on fee-for-service experience, the average cost of a member in an Intermediate Care Facility for the Intellectually Disabled is \$151,682, versus an average cost of \$43,487 for a person served through the HCBS ID waiver.*
- ✓ *Medicaid generates 10-20 percent of most hospitals' revenues, but is on average, about 50 percent of nursing facilities' revenue. In the area of services for people with disabilities, Medicaid is often the primary or only revenue source.*

Goals & Strategies

Under IA Health Link, DHS has enrolled the majority of the Medicaid members in MCOs. This initiative has created a single system of care to address health care needs of the whole person. This includes physical health, behavioral health, and long term care services and supports. Primary goals of the initiative include:

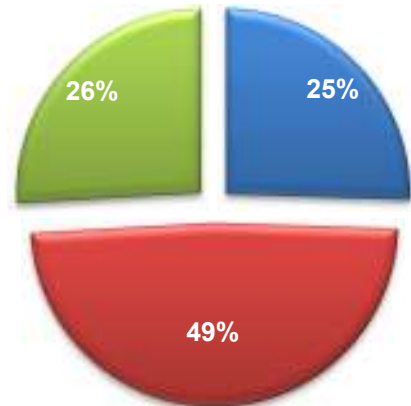
- Improved quality and access
- Greater accountability for outcomes
- Greater stability and predictability in the Medicaid budget

On December 16, 2014, the U.S. Department of Health and Human Services announced that Iowa was one of eleven State Innovation Model (SIM) grantees to test if value-oriented healthcare reforms could produce superior results when implemented in the context of a state-sponsored Plan. The grant of \$43 million was wrapped into Iowa's managed care approach via specific requirements for Value Based Purchasing (VBP) and a common quality measurement tool, called the Value Index Score (VIS) used across the delivery system and the MCOs. Because the VIS measures quality at a population health level, it ensures savings is linked to whole-system improvement supporting all members, not just managing isolated pockets of opportunity within the Medicaid population. This initiative is a multi-payor strategy that aligns Medicaid with Wellmark Blue Cross and Blue Shield (specifically) and Medicare (more generally) bringing the scale necessary to influence real delivery system reform across the state.



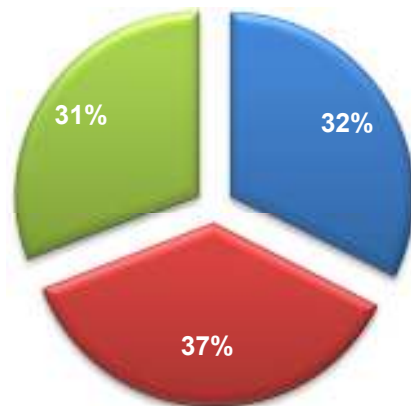
MCO Member Choice during initial enrollment period*

- Amerigroup (20,385)
- AmeriHealth Caritas (38,841)
- UnitedHealthcare (20,697)



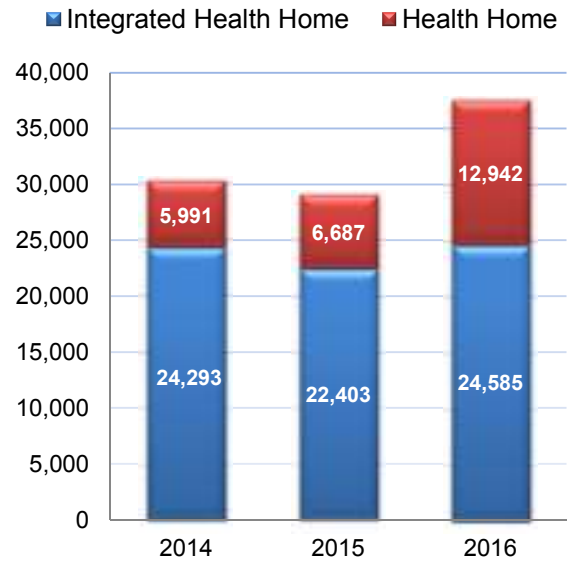
MCO Enrollment overall enrollment during initial enrollment period*

- Amerigroup (182,119)
- AmeriHealth Caritas (206,413)
- UnitedHealthcare (173,267)



*Data through June 16, 2016

Health Home and Integrated Health Home Recipient Enrollment



- Integrated Health Home Care Coordination contributed to a 19 percent reduction in emergency room visits and a 17 percent reduction in inpatient admissions.

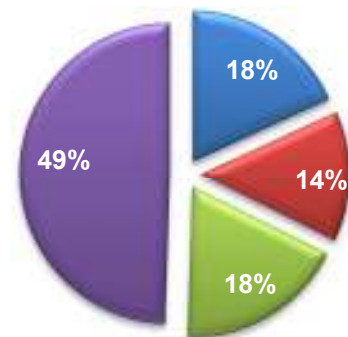
- ✓ *Medicaid collected over \$278 million in revenue through cost avoidance and recovery when other insurance is present in SFY16.*
- ✓ *Medicaid achieved savings and cost avoidance of \$43.8 million (state and federal) through the identification of overpayments, coding errors, and fraud and abuse in SFY16.*
- ✓ *The state expects to meet the Medicaid Modernization savings amount (\$110M) projected by the Medicaid Forecast Group, passed by the legislature, and signed by the Governor.*

Cost of Services

- **Costs remain low.** The trend in the growth of the cost per member has been very low. Per member costs increased by 3.2 percent in SFY16. Projected per member costs are projected to decrease by 7.5 percent in SFY17, increase by 0.6 percent in SFY18, and increase by 0.2 percent in SFY19.
- **Costs vary widely.** 58 percent of regular Medicaid members are children, but they account for only 18 percent of costs. Conversely, 19 percent of members are people with disabilities, but they account for 49 percent of Medicaid expenses.

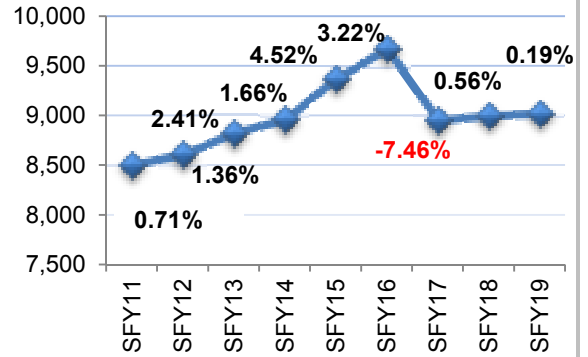
SFY16 Iowa Medicaid Expenditures

- Child (18%)
- Elderly (18%)
- Adult (14%)
- Disabled (49%)

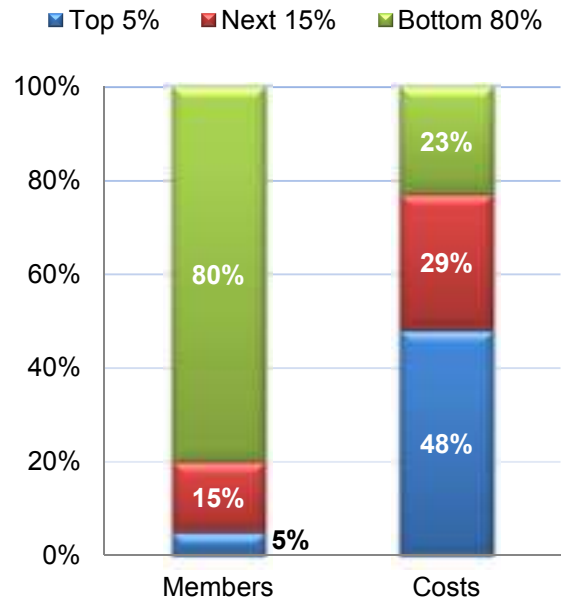


- The average annual cost for Medicaid services provided to a member is \$9,675 in SFY16 (all funds). Medicaid has a large number of healthy children with a low cost of \$2,952, and a small number of very costly elderly and disabled persons with an average cost of \$23,300.
- Members with chronic disease drive a significant share of Medicaid costs. Five percent of members account for 48 percent of acute care costs.
- As a result, a key initiative for Medicaid to reduce health care costs is implementation of health homes for members with chronic disease.
- Many of these high-cost members are also 'dual eligibles' (members who are eligible for both Medicare and Medicaid). More than half of dual eligibles are adults with a Serious Mental Illness. 70,000 dual eligibles cost more than \$1 billion.
- The Iowa Wellness Plan aligns a value-based payment strategy with Medicare, Wellmark and others to drive transformation in the healthcare delivery system to focus payment on results (outcomes) rather than quantity.
- Long term care costs account for more than half of Medicaid spending. Many individuals could be served in less expensive home and community based settings.
- Approximately half of Medicaid expenditures are for long term care costs, such as nursing facilities, home and community based supports, and services for persons with disabilities.

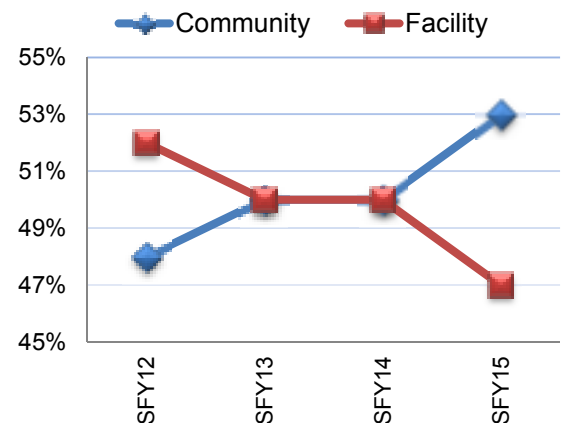
Change in Medicaid Cost Per Member



Chronic Care Within Medicaid



LTC Percentage of Expenditures by Setting During BIP Period



- ✓ *The top five percent high cost/high risk Medicaid members have an average of 4.2 chronic conditions, receive care from five different physicians, and receive prescriptions from six prescribers. They account for 90 percent of all hospital readmissions within 30 days, 51 percent of all preventable hospitalizations, 75 percent of all inpatient costs, 48 percent of all acute care costs, and 21 percent of the prescription drug costs.*
- ✓ *Medicaid payments to hospitals total over \$600 million per year.*

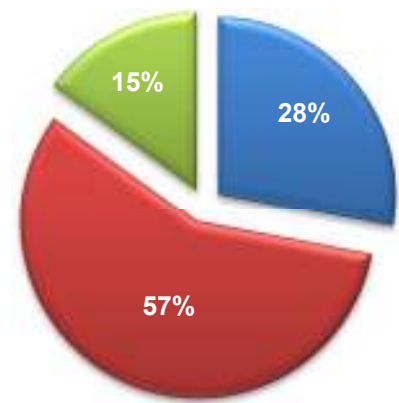
Funding Sources

Medicaid is funded by state general funds, other state funds, and federal matching funds through the FMAP.

- The total budget for SFY18 is \$4.94 billion:
- \$1.37 billion (27.7 percent) is state general fund.
 - \$2.81 billion (57.0 percent) is federal funding.
 - \$756.8 million (15.3 percent) is other state funding including drug rebates and other recoveries, Health Care Trust Fund (tobacco tax), and nursing facility and hospital assessment fee revenue.
- The total budget for SFY19 is \$5.09 billion:
- \$1.42 billion (27.8 percent) is state general fund.
 - \$2.89 billion (56.8 percent) is federal funding.
 - \$782.6 million (15.4 percent) is other state funding including drug rebates and other recoveries, Health Care Trust Fund (tobacco tax), and nursing facility and hospital assessment fee revenue.

SFY18 Funding

- State General Fund (28%)
- Federal (57%)
- Other Funding (15%)



SFY18 & SFY19 Budget Drivers

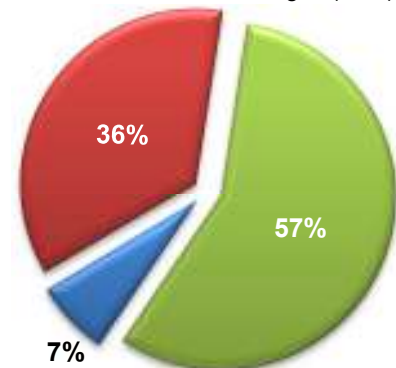
The total SFY18 Medical Assistance budget request reflects a \$47,857,454 (3.6 percent) general fund increase from the SFY17 Enacted Appropriation.

The total SFY19 Medical Assistance budget request reflects a \$98,662,120 (7.5 percent) general fund increase from the SFY17 Enacted Appropriation.

The SFY18 and SFY19 requests do not include funding for nursing facility rebasing, hospital rebasing, or the home health low utilization payment adjustment (LUPA) rate update.

Medicaid Increase by Budget Driver (Compared to the SFY17 Enacted Budget)

- Revenue Replacement (7%)
- Prior Year (36%)
- Current Year Trends/Changes (57%)

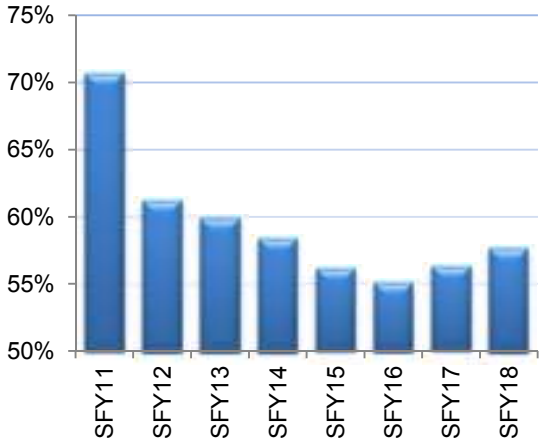


This request assumes a reauthorization of the hospital assessment fee program and that any changes will be budget neutral to the state. This program is currently scheduled to expire after SFY17, and failure to renew will have a negative financial impact on both the state and hospitals.

The Federal Medical Assistance Percentage (FMAP) rate (federal share) has decreased with the expiration of American Recovery and Reinvestment Act of 2009 (ARRA). Iowa's FMAP rate has also declined as Iowa's economy improves relative to other states; although that trend reversed in FY17.

- SFY11: 70.64 percent
- SFY12: 61.19 percent
- SFY13: 59.87 percent
- SFY14: 58.35 percent
- SFY15: 56.14 percent
- SFY16: 55.07 percent
- SFY17: 56.28 percent
- SFY18: 57.60 percent
- SFY19: 57.60 percent

Iowa FMAP Rate



The key drivers of the SFY18 increase are:

- Phase-down of the Iowa Health and Wellness Plan Newly Eligible FMAP (\$17.3 million)
- SFY17 unfunded need (\$17.4 million)
- Replacement of funds appropriated in SFY17 that will not be available in SFY18. This includes the Health Care Trust Fund and Palo Tax (\$3.3 million).
- Anticipated growth in enrollment and costs (\$59.6 million).
- This is offset by an increase in the regular Medicaid FMAP rate (\$49.7 million).

- ✓ *More than \$20.6 million of projected expenditure increases are due to an anticipated unfunded need in SFY17 and state revenue losses.*
- ✓ *The phase-down of the Iowa Health and Wellness Plan Newly Eligible FMAP results in a revenue decrease of \$17.3 million in SFY18.*

Legal Basis

Federal:

- Title XIX of the Social Security Act
- 42 CFR 440. 42 CFR 440.210 and 42 CFR 440.220

State:

- The Iowa Code Chapter 249A further defines the services and eligibility categories the Iowa Medicaid Program is required to cover. This offer maintains statutorily required services and populations.