



Improve Iowans' Health Status

Medical Assistance

Iowa Health and Wellness Plan

Children's Health Insurance Program

Medical Contracts

State Supplementary Assistance

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

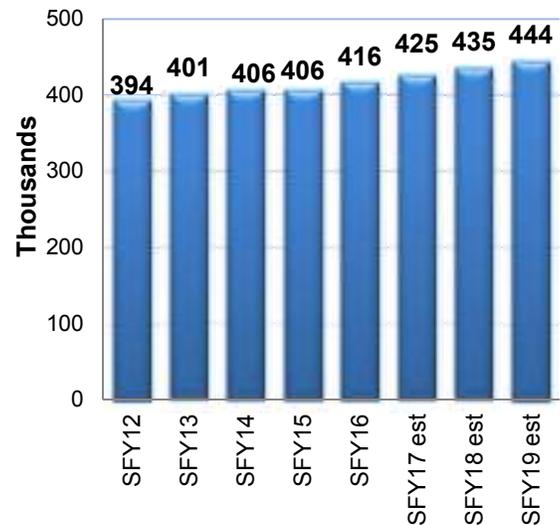
Medicaid is projected to serve nearly 770,000 Iowans (unduplicated) or 24.0 percent of Iowa’s population in SFY17 and over 795,000 (unduplicated) or 25.7 percent of Iowa’s population by SFY19.

- 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*

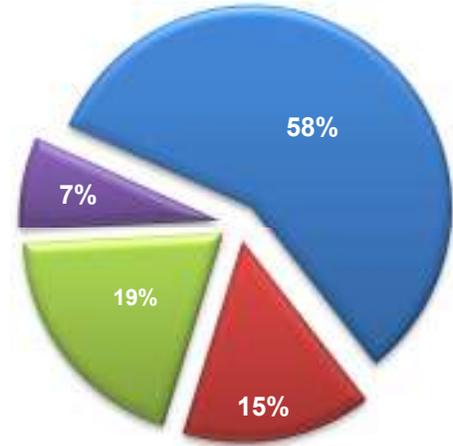


*Note: Excludes Health and Wellness Plan and Family Planning Waiver

- 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*

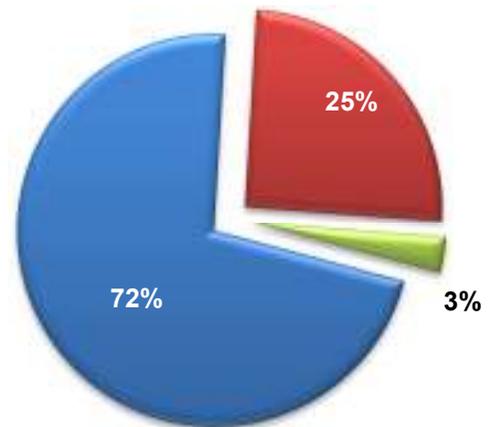
- Child (58%)
- Adult (15%)
- Disabled (19%)
- Elderly (7%)



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

Ending Medicaid Enrollment SFY16

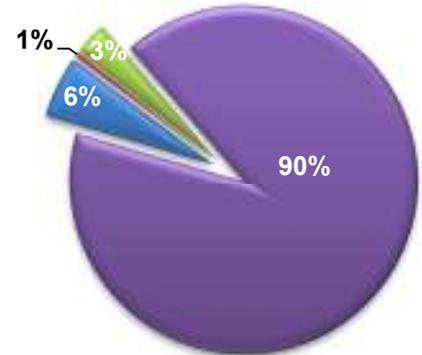
- Regular Medicaid (72%)
- Iowa Health and Wellness Plan (25%)
- Family Planning Waiver (3%)



- 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)



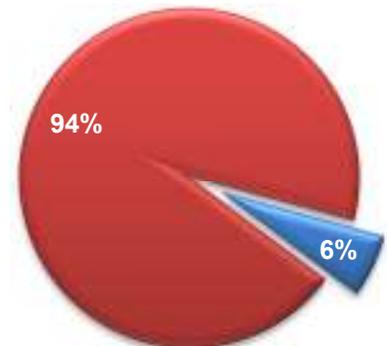
Medicaid Enrollment Change



*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.

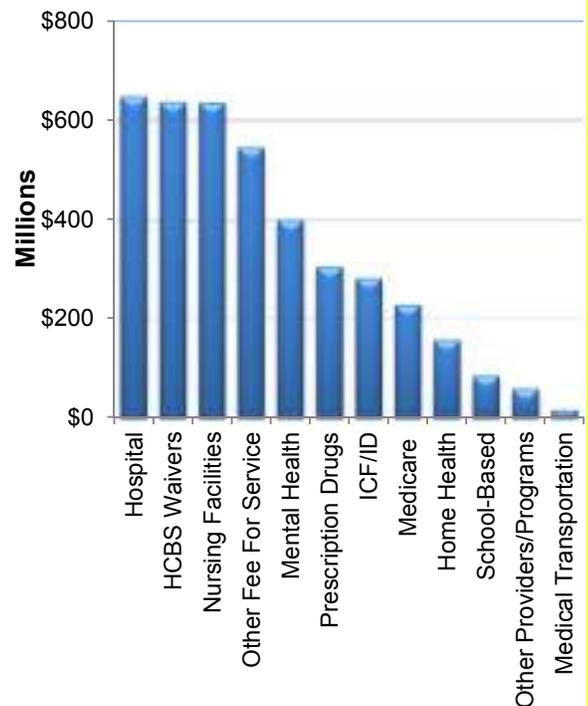
Services

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, 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.

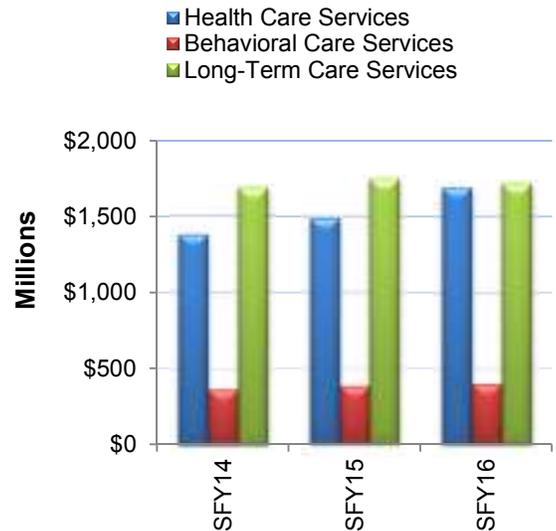
SFY16 Medicaid Expenditures by Provider Type \$4.0 Billion*



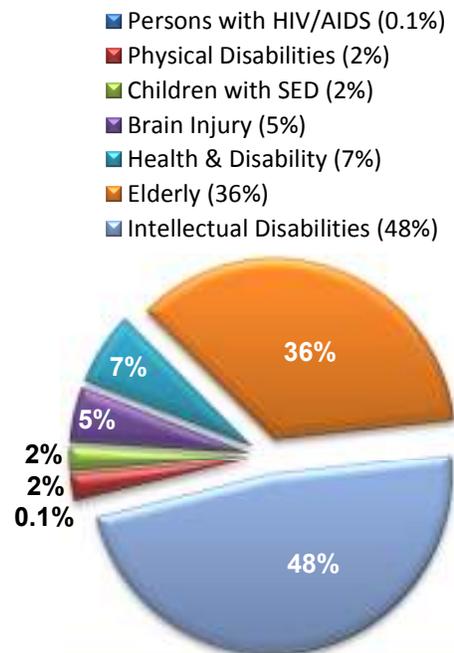
*Note: annualized FFS data and excludes Iowa Health and Wellness Plan

- **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:

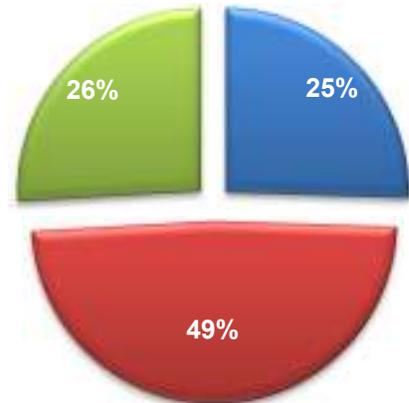
- Improved quality and access
- Greater accountability for outcomes
- Greater stability and predictability in the Medicaid budget

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.



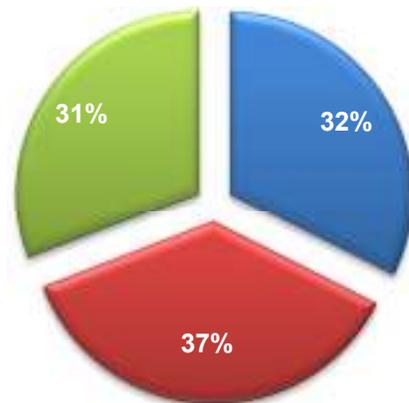
MCO Member Choice during initial enrollment period*

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



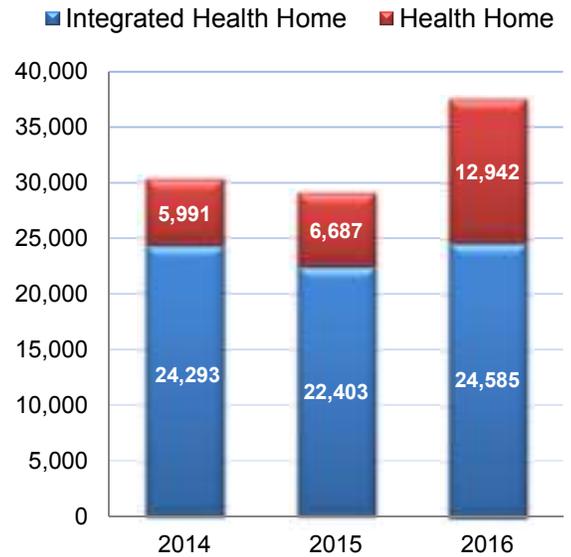
MCO Enrollment overall enrollment during initial enrollment period*

- 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.

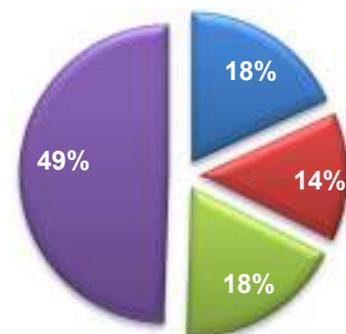
- ✓ *Medicaid collected over \$278 million in revenue through cost avoidance and recovery when other insurance is present in SFY16.*
- ✓ *Medicaid achieved savings and cost avoidance of \$43.8 million (state and federal) through the identification of overpayments, coding errors, and fraud and abuse in 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.

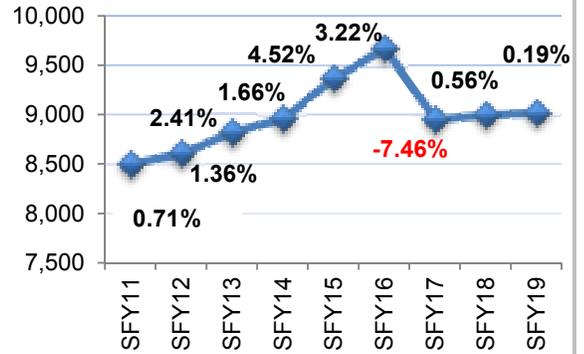
SFY16 Iowa Medicaid Expenditures

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

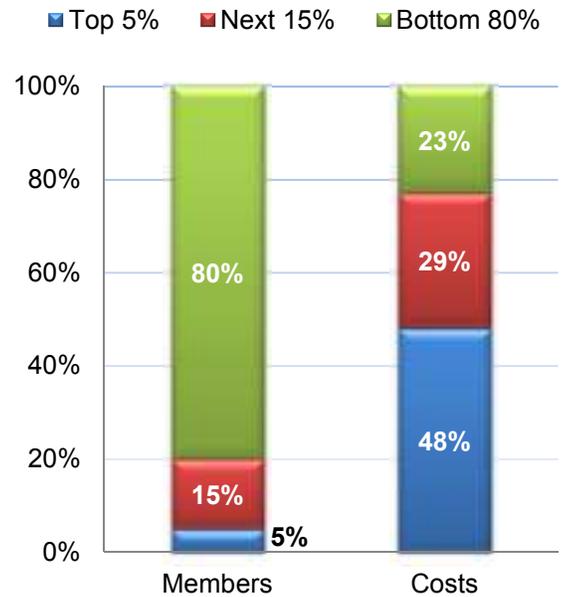


- The average annual cost for Medicaid services provided to a member is \$9,675 in SFY16 (all funds). Medicaid has a large number of healthy children with a low cost of \$2,952, and a small number of very costly elderly and disabled persons with an average cost of \$23,300.
- Members with chronic disease 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.

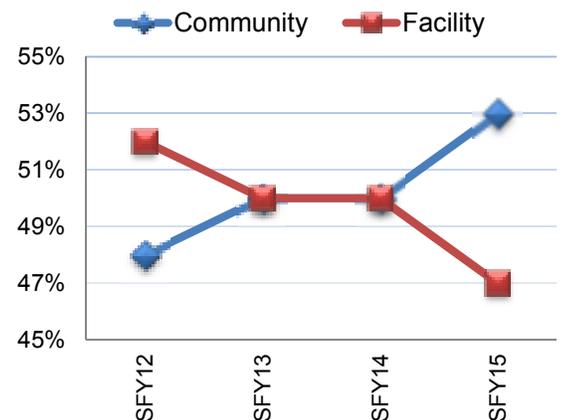
Change in Medicaid Cost Per Member



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

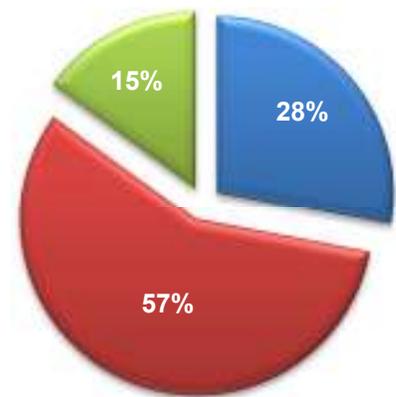
Medicaid is funded by state general funds, other state funds, and federal matching funds through the FMAP.

- 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

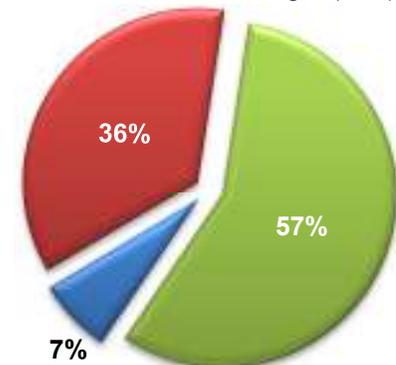
The total SFY18 Medical Assistance budget request reflects a \$47,857,454 (3.6 percent) general fund increase from the SFY17 Enacted Appropriation.

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%)

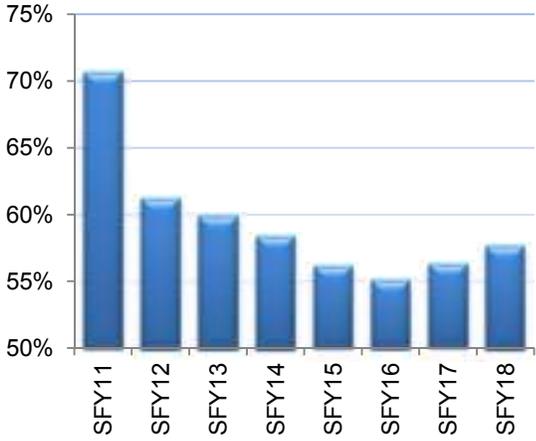


This request assumes a reauthorization of the hospital assessment fee program and that any changes will be budget neutral to the state. This program is currently scheduled to expire after SFY17, and failure to renew will have a negative financial impact on both the state and hospitals.

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.

Iowa Health and Wellness Plan



Purpose

The Iowa Health and Wellness Plan covers all Iowans, ages 19-64, with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The plan provides a comprehensive benefit medical and dental package, along with important program innovations, that will improve health outcomes and lower costs.

Medicaid Modernization is a major initiative in which the Iowa Department of Human Services (DHS) enrolled the majority of the Iowa Health and Wellness Plan members in managed care organizations (MCOs). DHS has contracted with MCOs to provide comprehensive health care services including physical health, behavioral health and long term supports and services. This initiative creates a single system of care to promote 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.

Who Is Helped

The Iowa Health and Wellness Plan expands access to health care coverage for low-income, uninsured adults.

The plan covers adults, ages 19-64 who are not otherwise eligible for comprehensive Medicaid, Medicare, or cost-effective employer sponsored insurance coverage:

- Persons with incomes 0-100 percent of FPL (\$11,880 for a family of one and \$16,020 for a family of two).
- Persons with incomes between 101 percent and 133 percent of FPL (\$11,880-\$15,800 for a family of one and \$16,020-\$21,307 for a family of two).

**Iowa Health and Wellness Plan
Estimated Average Enrollees**



✓ *During SFY16, the Iowa Health and Wellness Plan served an average of 146,385 individuals that were not previously covered by a full benefit Medicaid plan.*

Services

The Iowa Health and Wellness Plan provides health care to thousands of adults who would otherwise have no access to any type of healthcare regardless of income.

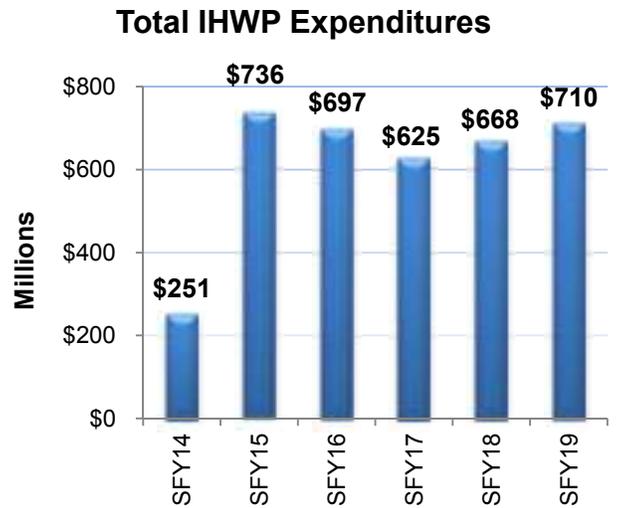
- The Plan offers innovations and reform in the delivery of health care services through leveraging care coordination models.
- The Plan provides a comprehensive benefit package that ensures coverage for all of the Essential Health Benefits (EHB) as required by the Affordable Care Act (ACA).

Covered Benefits

- Ambulatory patient services (e.g. Physician Services)
- Emergency Services
- Hospitalization
- Mental health and substance use disorder services, including behavioral health treatment
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services

	<ul style="list-style-type: none"> Comprehensive health services, equivalent to the State Employee Health Benefit Package. Robust provider network focused on primary care to assist in the coordination of health services and assist members with completing healthy behaviors. 	<ul style="list-style-type: none"> Home and community based services for persons with Chronic Mental Illness, equivalent to the Medicaid benefit Prescription drugs equivalent to the Medicaid benefit Preventive dental services and treatment equivalent to the Medicaid benefit 								
Goals & Strategies	<p>✓ <i>In SFY16, members have a unique dental coverage through the Dental Wellness Plan (DWP). DWP includes an earned benefit design to promote proactive, responsible use of the delivery system. Members who make regular visits to their dental providers gain access to ore services. Preventive dental exams count as a healthy behavior that is part of the premium waiver.</i></p> <p>Under IA Health Link, DHS enrolled the majority of the Iowa Health and Wellness Plan members in MCOs. This initiative is designed to create 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:</p> <ul style="list-style-type: none"> Improved quality and access Greater accountability for outcomes Greater stability and predictability in the Iowa Health and Wellness Plan budget <p>Goals of the Iowa Health and wellness Plan are also designed to improve Iowan’s health status:</p> <ul style="list-style-type: none"> Collect data on social determinants of health and patien confidence, through the use of health risk assessments. Implementing a new delivery system and payment model to promote improved care management, care coordination, and health care quality. Implementing a unique incentive plan to encourage development of cost-conscious consumer behavior in the consumption of health care services. 									
Cost of Services	<p>Participant financial contribution under the Iowa Health and Wellness Plan has unique and innovative features designed to encourage utilization of preventive care and overall health promotion and disease prevention through an incentive-based program.</p> <ul style="list-style-type: none"> No co-payments, except \$8 for using the emergency room when it is not a medical emergency. No monthly contributions or premiums in the first year. No contributions after the first year if the member completes preventive services and/or wellness activities. Monthly contributions only for adults with incomes at 50 percent or greater of the FPL if preventative services/wellness activities not completed. Estimated total state and federal cost projections do not include administrative costs. 	<p style="text-align: center;">Participant Individual Monthly Contributions</p> <table border="1"> <thead> <tr> <th>Federal Poverty Level</th> <th>Monthly Contribution</th> </tr> </thead> <tbody> <tr> <td>0 - 49%</td> <td>\$0</td> </tr> <tr> <td>50 - 100%</td> <td>\$5</td> </tr> <tr> <td>101 - 133%</td> <td>\$10</td> </tr> </tbody> </table>	Federal Poverty Level	Monthly Contribution	0 - 49%	\$0	50 - 100%	\$5	101 - 133%	\$10
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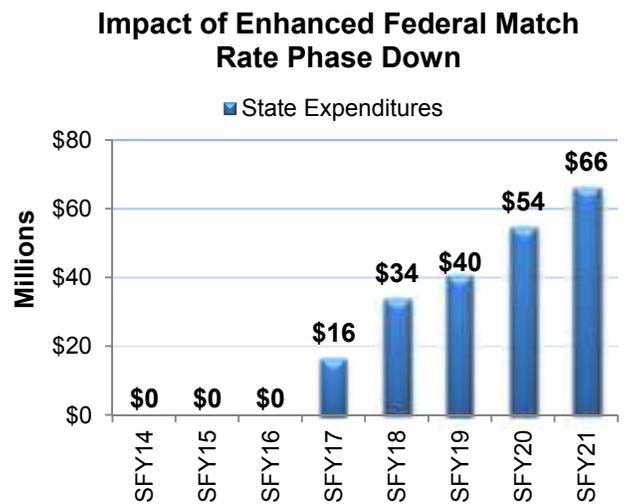
- An IHAWP member may claim a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning the call center designated by the department or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted.



- ✓ *Out of pocket costs can never exceed five percent of household income.*
- ✓ *The program provides incentives for members to engage in health and wellness activities through being able to have their monthly premiums waived.*
- ✓ *Enrollees who continue to complete health improvement behaviors in each 12-month period of enrollment will never be subject to the required monthly financial contribution.*

Funding Sources

- The vast majority of Health and Wellness Plan costs are reimbursed at the enhanced Federal Medical Assistance percentage (FMAP) for the New Adult Group under the ACA.
- A small portion of enrollees will receive regular federal match rates because they were previously eligible for other full benefit Medicaid eligibility groups.
- Administrative costs have match rates of 50%, 75%, or 90% depending on the type of expenditure.



Legal Basis

The Iowa Health and Wellness Plan operates under an 1115 demonstration waiver.

Federal:

- Section 1115 of the Social Security Act; Section 1902(a) (10) (B); Section 1902(a) (13) and (a) (30); Section 1902(a) (14); 1902(a) (23) (A); Section 1902(a)(4); Section 1902(a)(1); Section 1902(a) (34); Section 1902(a) (54).

State:

- Iowa Senate File 446

Children's Health Insurance Program

Healthy and Well Kids in Iowa (*hawk-i*) and *hawk-i* Dental-Only Plan



Purpose

The Children's Health Insurance Program (CHIP) provides health care coverage for children and families whose income is too high to qualify for Medicaid but too low to afford individual or work-provided health care. The purpose of CHIP is to increase the number of children with health and dental care coverage, thereby improving their health and dental outcomes.

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 CHIP and Healthy and Well Kids in Iowa (*hawk-i*) members in managed care organizations (MCOs). DHS has contracted with MCOs to provide comprehensive health care services including physical health, behavioral health and long term supports and services. This initiative created a single system of care to promote the delivery of efficient, coordinated and high quality health care and establishes accountability in health care coordination.

Who Is Helped

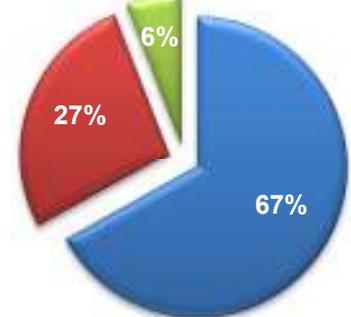
Enrollment in Iowa's CHIP program has been instrumental in providing coverage to thousands of uninsured children since 1998, and Iowa has historically been among the states with the lowest uninsured rate among children.

CHIP has three parts: a Medicaid expansion, a separate program called Healthy and Well Kids in Iowa (*hawk-i*), and a dental-only plan.

- **Medicaid expansion** provides coverage to children ages 6-18 whose family income is between 122 and 167 percent of the Federal Poverty Level (FPL), and infants whose family income is between 240 and 375 percent of the FPL.
- The *hawk-i* program provides coverage to children under age 19 in families whose family income is between 168 percent and 302 percent of the FPL based on Modified Adjusted Gross Income (MAGI) methodology.
- Total CHIP enrollment increased by 2.6 percent (1,523 enrollees) in SFY16, and is expected to increase by 2.5 percent (1,584 enrollees) in SFY17. Enrollment is projected to increase by 2.5 percent (1,620 enrollees) in SFY18 and increase by 2.5 percent (1,674) in SFY19. Projected increases are based on historical enrollment.

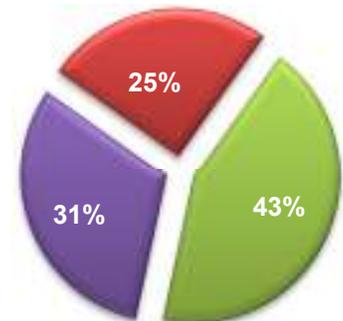
CHIP Members SFY16

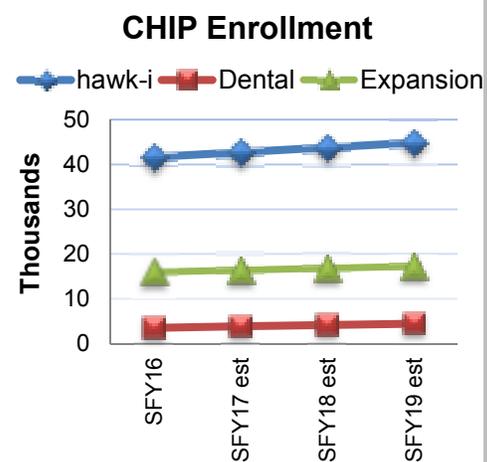
■ *hawk-i* (67%) ■ Expansion (27%)
 ■ Dental Only (6%)



Age of CHIP Children on June 30, 2016

■ 0-1 (0%) ■ 1 to 5 (25%)
 ■ 6 to 12 (43%) ■ 13 to 18 (31%)





- ✓ *As of June 30, 2016, 15,982 children were covered in the Medicaid expansion program; 41,702 in **hawk-i**; and 3,570 in the dental-only plan.*
- ✓ *Enrollment in the CHIP program increased to 61,254 in SFY16, and is expected to increase to 62,982 children in SFY17 and 64,747 children in SFY18.*
- ✓ *A comprehensive outreach campaign includes producing publications, free-and-reduced lunch mailings, statewide grassroots outreach, and by giving presentations to various groups who can assist with enrolling uninsured children in the **hawk-i** program. \$342,340 has been spent on outreach since 7/1/15.*

Services

The CHIP program is administered under Title XXI of the Social Security Act and covers a comprehensive range of health and dental services for Iowa’s children who meet the program’s eligibility criteria.

Beginning April 1, 2016, members with CHIP program began having their services administered through a managed care entity: Amerihealth Caritas Iowa Inc., Amerigroup Iowa Inc., and United Healthcare Plan of the River Valley Inc.

Key components of the CHIP program are:

- Children covered by the Medicaid expansion receive covered services through existing Medicaid provider networks. This activity receives enhanced federal funding through Title XXI, rather than Title XIX.
- **hawk-i** services include, but are not limited to, doctor visits, inpatient and outpatient hospital, well-child visits, immunizations, emergency care, prescription medicines, eye glasses and vision exams, dental care and exams, speech, occupational, and physical therapy, ambulance, and mental health and substance abuse care.
- The **hawk-i** program pays premiums to plans.
- Required dental coverage includes diagnostic and preventive services, routine and restorative services, endodontic and periodontal services, cast restorations, prosthetics and medically necessary orthodontia.

- ✓ *Iowa is one of only a limited number of states with CMS-approved plans which include basic dental coverage and medically necessary orthodontic coverage.*
- ✓ *The covered services under **hawk-i** are different from regular Medicaid and are approximately equivalent to the benefit package of the state’s largest Health Management Organization (HMO) at the time the program was initiated.*

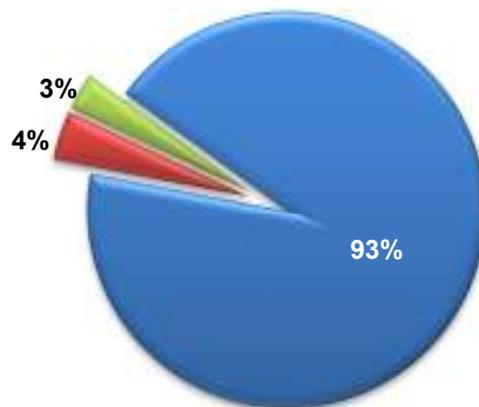
Goals & Strategies

DHS enrolled the majority of the CHIP and *hawk-i* members in managed care organizations (MCOs). This initiative is designed to create 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 CHIP and *hawk-i* budget

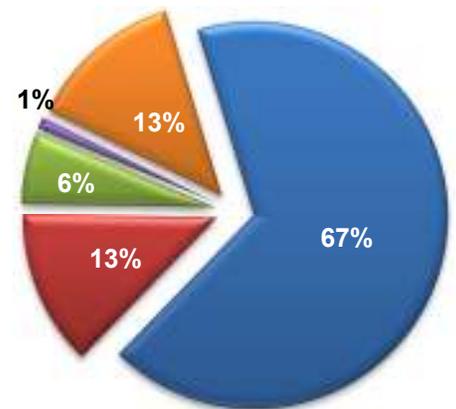
2016 Satisfaction Survey Is the Premium Affordable?

■ Yes (93%) ■ No (4%) ■ Not Answered (3%)



SFY16 Satisfaction With Care

■ Very Satisfied (67%)
■ Satisfied (13%)
■ Neutral (6%)
■ Unsatisfied (1%)
■ Extremely Unsatisfied (0%)
■ Not Answered (13%)



<p>Cost of Services</p>	<p>CHIP is projected to cover 62,982 children in SFY17 at a total (federal and state) program cost of \$127.3 million.</p> <ul style="list-style-type: none"> Families pay a monthly premium of \$10-\$20 per child with a maximum of \$40 based on family income. The SFY17 total annual cost per member for Medicaid expansion children is \$2,092. The SFY17 total annual cost per member for <i>hawk-i</i> children enrolled with the health plan is \$2,190. This cost represents the premiums paid to health plans. The SFY17 average annual cost for children in dental only program is \$276. 	<p><i>hawk-i</i> Family Premiums in June 2016</p> <table border="1"> <thead> <tr> <th>Premium Amount</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>\$0</td> <td>29%</td> </tr> <tr> <td>\$5</td> <td>1%</td> </tr> <tr> <td>\$10</td> <td>20%</td> </tr> <tr> <td>\$15</td> <td>1%</td> </tr> <tr> <td>\$20</td> <td>36%</td> </tr> <tr> <td>\$40</td> <td>12%</td> </tr> </tbody> </table>	Premium Amount	Percentage	\$0	29%	\$5	1%	\$10	20%	\$15	1%	\$20	36%	\$40	12%
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<ul style="list-style-type: none"> ✓ When all costs for administration and services are included, the average total annual cost per person in the CHIP program is projected to be \$2,178 in SFY17. ✓ The SFY17 total annual cost of administering the CHIP program (including the Third Party Administrator, claims processing, outreach and state staffing) is \$7.4 million. 																
<p>Funding Sources</p>	<p>The CHIP program is authorized and funded through Title XXI of the Social Security Act. Funding is authorized through September 30, 2017. The budget request assumes the program continues in its current form in SFY18 and SFY19.</p> <ul style="list-style-type: none"> The SFY17 appropriation amount is \$9,176,652. In SFY17, the state will pay a match rate of 7.6 percent, with a 92.4 percent federal match for CHIP. In SFY18, the state will pay a match rate of 6.68 percent (estimated). Approximately \$8.0 million in revenue from enrollee premiums, drug rebates, and other recoveries are projected to be collected in SFY17. 	<p>CHIP Funding SFY17</p> <table border="1"> <thead> <tr> <th>Funding Source</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Federal</td> <td>86%</td> </tr> <tr> <td>State</td> <td>7.3%</td> </tr> <tr> <td>Other</td> <td>6.7%</td> </tr> </tbody> </table>	Funding Source	Percentage	Federal	86%	State	7.3%	Other	6.7%						
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	<ul style="list-style-type: none"> ✓ <i>The federal CHIP match rate has been increasing since SFY16, and is projected to increase by 6.6 percent in SFY17. This rate change will result in an estimated \$8.4 million increase in funding.</i> ✓ <i>The enhanced CHIP match is projected to end September 30, 2019, so will be in place for both SFY18 and SFY19.</i> ✓ <i>Federal funding for CHIP is authorized to end September 30, 2017. If Congress does not extend the authorization, CHIP will no longer receive any federal funding. Iowa's CHIP program will have to make decisions about the program. For the Medicaid Expansion (ME) part of Iowa's CHIP, ME will continue but at the Medicaid FMAP instead of the enhanced CHIP FMAP. The hawk-i part of CHIP can either:</i> <ul style="list-style-type: none"> ○ <i>Be discontinued</i> ○ <i>Move the hawk-i members to Medicaid and receive the Medicaid FMAP</i> ○ <i>Continue but with all state funding</i>
<p>Legal Basis</p>	<p>Federal:</p> <ul style="list-style-type: none"> • Title XXI of the Federal Social Security Act. The Affordable Health Care Act (ACA), signed into law on March 23, 2010, continues CHIP programs through September 30, 2019. The ACA prohibits states from reducing their current eligibility standards until this date. Under Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), funding for the program is authorized through September 30, 2017. <p>State:</p> <ul style="list-style-type: none"> • Chapter 514I of the Code of Iowa; 441 IAC Chapter 86

Medical Contracts



Purpose	<p>The department implemented the IA Health Link managed care program for the majority of the Medicaid population on April 1, 2016. Most Medicaid members are now being served by three managed care companies, or managed care organizations (MCOs). The Iowa Medicaid Enterprise (IME) continues to operate a fee for service program for the Medicaid members not enrolled in managed care.</p> <p>Medical contracts include those contracts that enable IME staff as the federally designated single state Medicaid agency to operate the fee-for-service (FFS) program, oversee the MCOs, and operations required for the overall Medicaid program. To carry out these functions, IME has 41 full time state employees, including 14 Health Insurance premium Payment (HIP) staff. There are 9 performance based contracts with vendors which serve as the primary support to IME staff for both the MCO and FFS programs. With the implementation of managed care, other specialized vendors have been added. In addition to these contracts, IME has a host of contracts with other state agencies and entities to provide services and activities to support Medicaid, <i>hawk-i</i>, and Iowa Health and Wellness Plan members.</p>
Who Is Helped	<p>Vendors enable IME to operate the state Medicaid and <i>hawk-i</i> programs. Medicaid membership fluctuates, and it generally serves around 650,000 members through the various programs. About 575,000 to 600,000 members are served in managed care and from 40,000 to 70,000 are served in the FFS program. Many served in the FFS program will transition into managed care after their initial enrollment period.</p>
Services	<p>IME has a total of 55 contracts. The following are the primary contracts pertaining to fee for service and MCO and the remaining contracts are with a variety of agencies to provide related services.</p> <p>External Quality Review Organization (EQRO) carries out review and quality assurance functions required by CMS. These functions are designed to assure the integrity of the managed care services.</p> <p>Core Services processes all fee for service claims, processes managed care organization capitation rates, operates systems including the Medicaid Management Information System (MMIS) and manages the mailroom operations.</p> <p>Medical Services provides clinical support such as performs all initial Level of Care (LCO) decisions for waiver and institutional care; approves MCO recommended LOC changes and all FFS LOC reviews, provides utilization management and quality assurance for the fee for service members and carries out quality assurance for both the FFS and the managed care programs.</p> <p>Member Services is the State's Medicaid Managed Care enrollment broker. It provides customer services to the fee for service population and provides assistance to members seeking issue resolution with the managed care organizations.</p> <p>Milliman establishes the managed care capitation rates and assists in the review of expenditures data.</p> <p>Pharmacy Medical Services maintains the Preferred Drug List (PDL) that applies to all Medicaid members. In addition this vendor processes prior authorization (PA) requests and answers the Pharmacy Hotline for FFS members.</p> <p>Pharmacy Point of Sale (POS) collects drug rebates from manufacturers. In addition this vendor responds to pharmacy provider questions and processes FFS pharmacy claims.</p> <p>Program Integrity (PI) identifies potential fraud, waste and abuse through oversight and cost avoidance strategies. PI coordinates with the department, the MCOs, the Attorney General's Office and the Medicaid Fraud Control Unit (MFCU) in the Department of Inspections and Appeals. In addition PI will assist in validating managed care data.</p>

Provider Cost Audit and Rate Setting performs rate setting, cost settlement and cost audit functions and technical assistance to both providers and managed care organizations. Provider rates serve as the rate floor for managed care organizations unless otherwise negotiated.

Provider Services enrolls all Medicaid providers including FFS and managed care. Provider Services provides direct support to providers in the fee for service programs and coordinates with the managed care organizations to provide training to providers. In addition, Provider Services provide assistance to providers seeking issue resolution with the managed care organizations.

Revenue Collections carries out Third Party Liability (TPL) functions for the fee for service members and estate recovery for all members.

3M implements the Value Index Score (VIS) for quality measurement used by MCOs and providers. The VIS is used to inform value based purchasing of health care services which is a MCO contractual requirement.

University of Iowa reports HEDIS and CAHPS measures which are indications of health care outcomes for both the FFS program and the MCOs.

- ✓ *Medicaid processed over 32 million claims in SFY16. The average time from the receipt of an electronic claim form to payment was six days in SFY16.*
- ✓ *Program Integrity saved Medicaid \$43.84 million in SFY16 through the identification of overpayments, coding errors, and fraud, waste and abuse. The Recovery Audit contract accounted for approximately \$8.0 million of the \$43.84 million recovered.*
- ✓ *Historical program integrity and third party liability recoveries were irrelevant in the development of initial managed care capitation rates. MCOs are expected to be at least as efficient at recovery of inappropriate Medicaid payments as Iowa Medicaid was in FFS.*

Goals & Strategies

By modernizing the Medicaid program, the IA Health Link initiative aims to:

- Improve quality and access
- Promote accountability for outcomes
- Create a more predictable and sustainable Medicaid budget

Results:

Preferred Drug List Savings

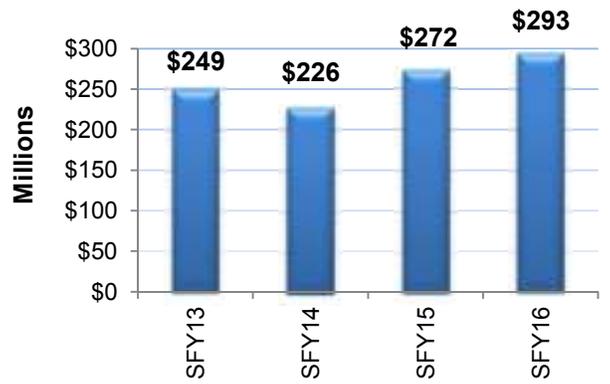


Program Integrity Savings

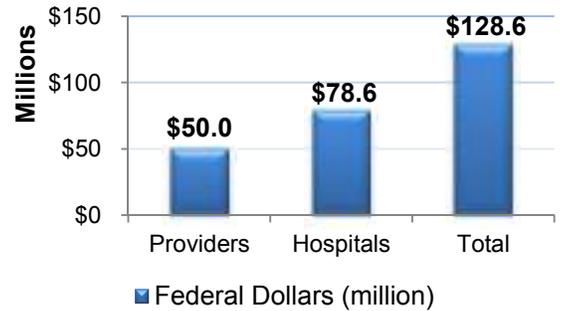




Revenue Collections



Medicaid Electronic Health Record Payments (since January, 2011)

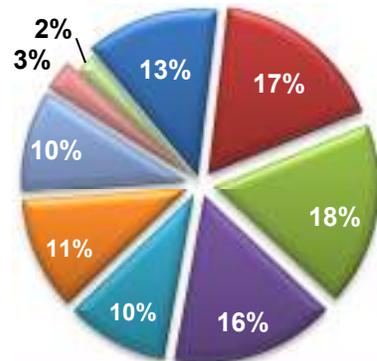


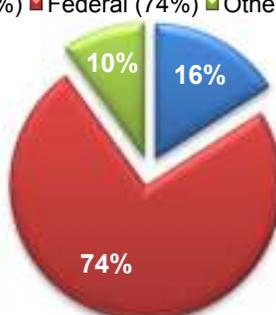
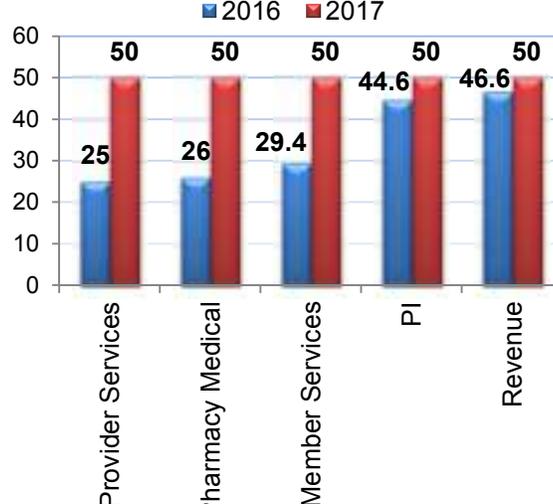
Cost of Services

- Medicaid administrative costs go towards managing the program, processing claims, managing member usage of services, provider and member assistance, rate setting, and recovering funds from other payors or providers.

SFY17 Projected Share of State Expenditures by IME Units

- Medical Services (13%)
- PCA (18%)
- Revenue (10%)
- Provider Services (10%)
- Pharm Medical (2%)
- CORE (17%)
- PI (16%)
- Member Services (11%)
- POS (3%)



<p>Funding Sources</p>	<ul style="list-style-type: none"> IME Medical Contracts are funded with state and matching federal funds. The state share of funding varies for each contract ranging from 10 percent (e.g. system development), 25 percent (e.g. CORE, Medical Services, and Provider Services) to 50 percent for others (e.g. Revenue Collections, PCA). The federal matching rate is determined by the makeup of vendor personnel and activities performed. 	<p style="text-align: center;">Medical Contracts Funding Share SFY17</p> <p style="text-align: center;">■ State (16%) ■ Federal (74%) ■ Other State (10%)</p>  <p style="text-align: center;">State Share Percentage Change by Contract</p> <p style="text-align: center;">■ 2016 ■ 2017</p> 
<p>SFY18 & SFY19 Budget Drivers</p>	<p>This request includes \$1,268,000 to replace one-time Autism Support carry-forward funds appropriated in SFY17 that will not be available in SFY18 or SFY19.</p>	
<p>Legal Basis</p>	<p>Federal:</p> <ul style="list-style-type: none"> Title XIX of the Social Security Act. 42 CFR 434.1. Section 1902(a) (4) of the Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan. 434.1(b) sets forth the requirements for contracts with certain organizations for furnishing Medicaid services or processing or paying Medicaid claims or enhancing the agency's capability for effective administration of the program. 	

State Supplementary Assistance



Purpose State Supplementary Assistance (SSA) helps low-income elderly or disabled Iowans meet basic needs and reduces state spending for Medicaid.

- Who Is Helped**
- SSA eligibility criteria include:
- Requirements about disability or age as defined by Social Security standards.
 - Receipt or eligibility to receive Supplemental Security Income (SSI).
 - Citizenship and residency.
 - Limitations on income and assets.

There are seven SSA groups.

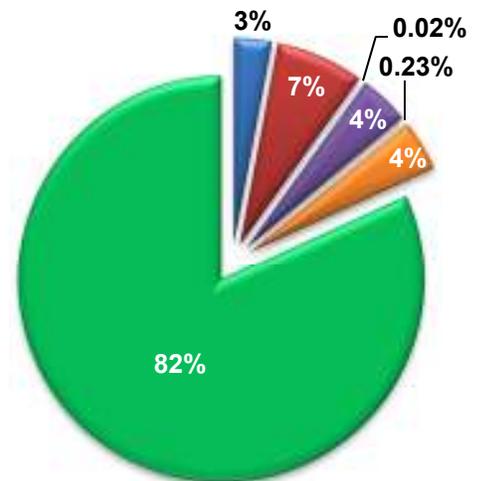
Over 82 percent of SSA recipients are in the Supplement for Medicare and Medicaid Eligible (SMME) group. While providing a \$1 monthly payment to the person, it saves the state money that would otherwise be paid by the state for the recipients' Medicare Part B premiums.

In SFY16 an average of 17,276 cases received an SSA benefit. A case may be a single person or a couple if living together.

- Examples of the monthly income requirements:
- Residential facility, monthly income of \$1,034 or less.
 - In-Home Health-Related Care, monthly income of \$1,213 or less.
 - Blind, monthly income of \$755 or less.

Recipients by Coverage Group SFY16

- Blind Allowance (3%)
- Dependent Person Allowance (7%)
- Family Life Home (.02%)
- In-Home Health-Related Care (4%)
- Mandatory State Supplement (.23%)
- RCF Assistance (4%)
- SMME Assistance (82%)



May not equal 100% due to rounding.

✓ *In addition to receiving SSA, most recipients also receive Medicaid.*

<p>Services</p>	<p>State Supplementary payments provide cash payments to help meet basic needs.</p> <p>Individuals receiving In-Home Health-Related Care, Residential Care Facility, and Family Life Home services help pay for the cost of their care through an assessed client participation amount. SSA pays the difference between the actual cost of care and the client payment amount.</p> <p>Monthly benefits:</p> <ul style="list-style-type: none"> • Dependent Person Allowance, up to \$377. • In-Home Health-Related Care (IHHRC), up to \$480. • Blind Allowance, up to \$22. • Mandatory Supplement, an average of \$168. • Supplement for Medicare and Medicaid Eligible (SMME), \$1 per month. • Residential Care Facility (RCF) Assistance, up to \$1,034. • Family Life Home Payment, up to \$142. 	<p>Expenditures by Coverage Groups in SFY16</p> <ul style="list-style-type: none"> ■ Family Life Home (.07%) ■ SMME (1%) ■ Mandatory Supplement (0.8%) ■ RCF (21%) ■ Blind Allowance (1%) ■ IHHRC (31%) ■ Dependent Person (44%) <p>May not equal 100% due to rounding.</p>
	<ul style="list-style-type: none"> ✓ <i>Most SSA payment types must meet a minimum payment amount set by the federal government. States can pay more but not less. Iowa is at the federal minimum for all but IHHRC.</i> ✓ <i>RCF and Dependent Person payment levels are affected by Social Security cost of living allowance increases. The payments must increase each January to equal the increased federal minimum payments.</i> 	
<p>Goals & Strategies</p>	<p>Goal: Provide Access to Health Care Services</p> <p>Strategies:</p> <ul style="list-style-type: none"> • Access federal dollars for payment of Medicare Part B premiums for more Medicaid members through the SMME coverage group. • Continue to provide assistance in the least restrictive setting for elderly and disabled recipients. 	<p>Results in SFY16:</p> <ul style="list-style-type: none"> • The number of SMME participants changed very little during SFY16, maintaining the amount the state pays for the Medicare Part B premiums for those individuals.
<p>Cost of Services</p>	<p>The average cost of providing SSA varies greatly between coverage groups, ranging from \$12 annually for SMME Assistance to \$5,369 for persons receiving In-Home Health-Related Care Assistance.</p>	
<p>Funding</p>	<p>The total budget for SFY17 is \$11,611,442.</p> <p>Funding is entirely from the state general fund.</p>	

Sources	<ul style="list-style-type: none"> ✓ <i>State Supplementary Assistance is used to meet the Medicaid federal Maintenance of Effort (MOE) requirement.</i> ✓ <i>Failure to fully fund the SSA program puts the state at risk of losing federal funding for the state's Medicaid program as the result of not meeting Medicaid MOE requirements.</i> ✓ <i>There was no Social Security COLA in CY2016. In July 2016, the Annual Social Security Trustee Report projected a COLA of 0.2 percent for CY2017, 2.9 percent for CY2018, and 2.6 percent for CY2019. Actual COLAs are typically announced in the late fall and may be different from the Trustee's report.</i>
Legal Basis	<p>Federal:</p> <ul style="list-style-type: none"> • SSA benefits are an MOE requirement for the Medicaid program • Code of Federal Regulations: 20 CFR 416.2095 and 416.2096 <p>State:</p> <ul style="list-style-type: none"> • Iowa Code Chapter 249 • Iowa Administrative Code 441 IAC Chapters, 50-54 and 177