

Improve Iowans' Health Status

**Medical Assistance
Iowa Health and Wellness Plan
Children's Health Insurance Program
Health Program Operations
State Supplementary Assistance**

Medical Assistance

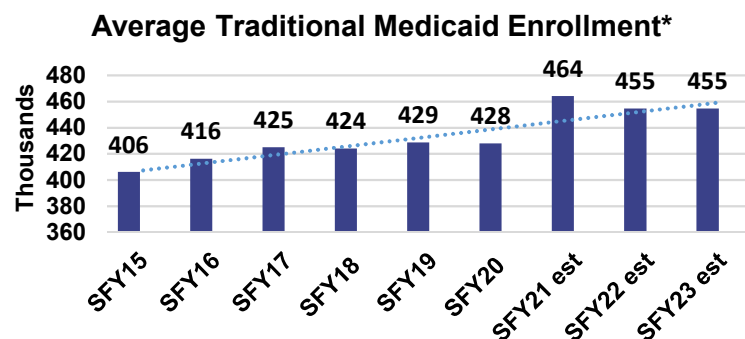
Medicaid – Title XIX

DESCRIPTION

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. Medicaid is Iowa's second largest health care payer.

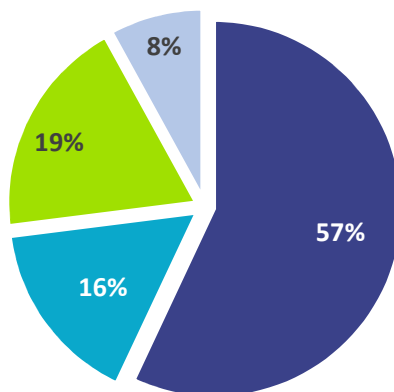
WHO IS HELPED

Medicaid is projected to serve nearly 752,000 Iowans (unduplicated) or 23.7 percent of Iowa's population in SFY21 and over 737,000 (unduplicated) or 23.25 percent of Iowa's population by SFY22.



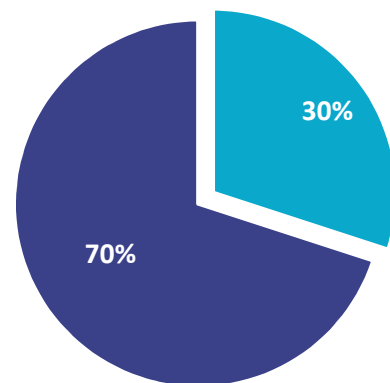
*Excludes Health and Wellness Plan and State Family Planning program

Average Traditional Medicaid Enrollment in SFY20



■ Child (57%) ■ Adult (16%)
■ Disabled (19%) ■ Elderly (8%)

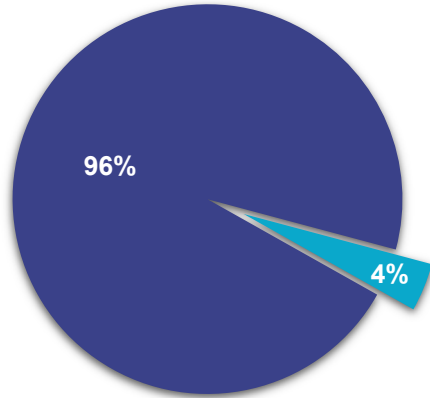
Medicaid Enrollment in SFY20 by Program



■ Iowa Health and Wellness Plan (30%)
■ Traditional Medicaid (70%)

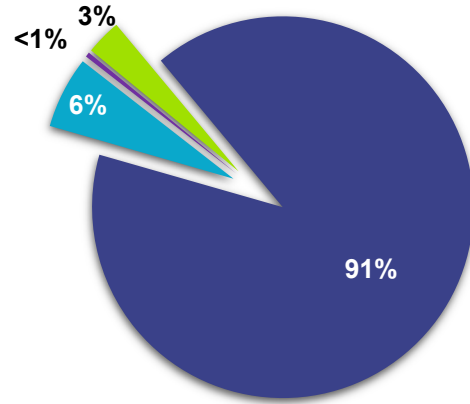
Estimated Enrollment Fee-for-Service v Managed Care

- Fee-for-Service 4%
- Managed Care Organization 96%



Recipients by Setting (MCO Members) SFY20

- HCBS Waivers (26,618)
- ICF/ID (1,757)
- NF (13,187)
- Home (395,525)



The majority of Members are enrolled in Managed Care.

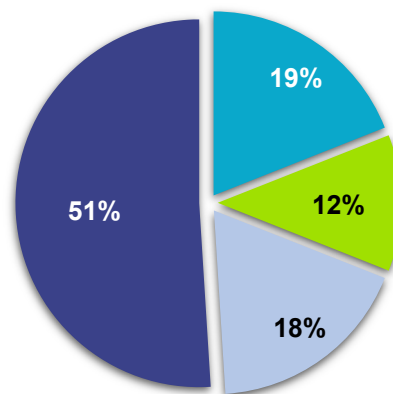
COST OF SERVICES & FUNDING SOURCES

Costs vary widely by eligibility group. 57 percent of traditional Medicaid members are children, but they account for only 19 percent of costs. Conversely, 19 percent of members are people with disabilities, but they account for 51 percent of Medicaid expenses.

The average annual cost for Medicaid services provided to a member was \$10,201 in SFY20 (all funds). Medicaid has a large number of healthy children with a low cost of \$3,580, and a small number of very costly elderly and disabled persons with an average cost of \$27,723.

SFY20 Iowa Medicaid Expenditures

- Child (19%)
- Adult (12%)
- Elderly (18%)
- Disabled (51%)

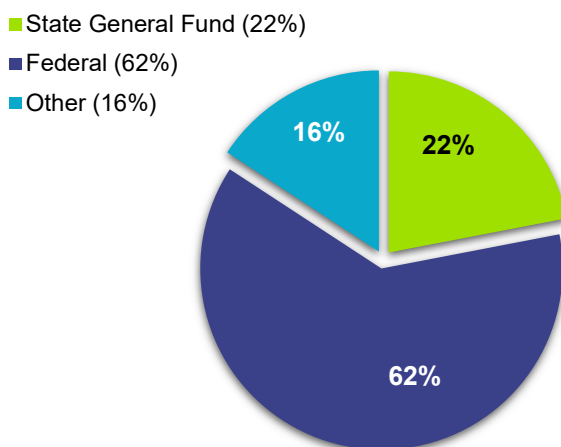


Iowa's Medicaid program is funded by state general funds, other state funds, and federal matching funds based on the Federal Medical Assistance Percentage (FMAP).

The current budget for SFY21 is \$6.64 billion:

- \$1.46 billion (22.0 percent) is state general fund.
- \$4.13 billion (62.2 percent) is federal funding.
- \$1.05 billion (15.8 percent) is other funding including drug rebates and other recoveries, Health Care Trust Fund (tobacco tax), and nursing facility and hospital assessment fee revenue.

SFY21 Funding



PROGRAM REVISION to BENEFIT IOWANS

Program revisions initiated and/or implemented in the past year include:

- The creation of a universal prior authorization (PA) form to streamline PA submission and allow the same form to be submitted to IME or the MCOs.
- Removing the Brain Injury (BI) and Elderly Waiver Caps in order to make sure members were able to access needed services.
- Initiating an emergent, urgent prioritization program for individuals on the BI Waiver waitlist.
- Adding AEAs and LEAs as originating sites for telehealth services.
- Added Federally Qualified Health Care Centers (FQHC) as distant sites for telehealth services.
- Initiated a Maternal Fetal specialty enhanced payment.
- A variety of other provider and member benefit flexibilities have been implemented in response to the COVID-19 pandemic.

Medical Assistance

Medicaid – Title XIX

BUDGET DRIVERS

Key factors impacting the Medical Assistance budget are provided below.

SFY20

- The end of session projected SFY20 balance was \$120.6 million.
This surplus was primarily due to the 6.2% COVID-19 enhanced FMAP which was implemented in March 2020 and effective beginning January 2020.
- The year-end balance is currently projected to be \$185.5 million; a \$64.9 million increase from the end of session estimate. The primary reasons for the increase include:
 - Increased Health Care Trust Fund revenue: \$14 million
 - COVID-19 enhanced FMAP savings related to the Medicare Part D claw back for dual eligibles: \$9 million
 - Payment obligations shifting from SFY20 to SFY21: \$37 million
 - This is a timing difference where both revenue and expenses will move to SFY21.

SFY21

- Base expenditures are projected to increase significantly in SFY21. This is primarily due to COVID-19 related enrollment impacts, including maintenance of effort (MOE) related to the enhanced FMAP. Most of these changes were considered in the SFY21 enacted budget.
- The SFY21 year-end balance is currently projected at \$70.4 million. The surplus is primarily due to extension of the COVID-19 enhanced FMAP from 9/30/2020 to 12/31/2020.
- This surplus estimate does not consider the impact of potential MCO capitation rate changes that may be made January 2021. While the impact of the rate review that will be conducted for this period is not known, the following factors will be considered:
 - Trend; including COVID-19 impacts
 - Increases, e.g. telehealth and home delivered meals
 - Decreases, e.g. voluntary procedures, fewer visits
 - Nursing facility COVID-19 payments
 - Any additional provider enhanced payments resulting from COVID-19

SFY22

- Due to the assumed phase-out of the COVID-19 enrollment impacts (MOE related to the enhanced FMAP) and other one-time payments, total expenditures (federal and state share) are currently projected to be approximately five percent lower in SFY22 than in SFY21.
- This decrease is offset by additional demands on state dollars due to the following:
 - A reduction in other state funds resulting from lower prior year-carry-forward funds.
 - Expiration of the COVID-19 enhanced FMAP.
- The net result of these changes is an additional budget need of \$89.7 million.
- The SFY22 budget request is highly sensitive to the SFY21 MCO rate change. For example, if the January 2021 rate change increases state spending by \$20 million, this could increase the SFY22 budget need by up to \$40 million (from \$89.7 million to \$129.7 million).
 - \$20 million due to a lower SFY21 carry-forward (\$50.4 million rather than \$70.4 million).
 - \$20 million to fund the ongoing expense in SFY22.

SFY23

- Enrollment in SFY23 is expected to be similar to SFY22, and because MCO capitation rate changes are not incorporated in current estimates, there is little change in projected MCO payments.
- Non-MCO payments are projected to decrease slightly in SFY23.
- With these changes, state expenditures are expected to decrease by \$8.2 million. However, state revenues are also expected to decline by \$68.5 million, primarily due to the lack of carry-forward funds.
- As a result, the total state budget need is currently projected to increase by \$60.3 million; from \$89.7 million in SFY22 to \$150.0 million in SFY23.

Medical Assistance Financial Summary

Category	SFY20 Department Estimate	SFY21 Department Estimate	SFY22 Department Request	SFY23 Department Request
Revenue				
General Fund	1,516,364,409	1,459,599,409	1,459,599,409	1,459,599,409
Prior Year Carry-Forward	87,888,114	185,521,867	70,357,446	-
Other State Funds	302,101,142	289,920,774	293,480,693	295,291,693
Total Revenue	1,906,353,665	1,935,042,049	1,823,437,548	1,754,891,102
Expenditures				
MCO Payments	1,657,098,963	1,745,538,325	1,700,658,471	1,700,294,697
Health Insurer Fee	-	25,613,294	-	-
Non-MCO Payments	325,412,030	360,780,612	368,619,541	363,932,762
Revenue Offsets	(196,490,586)	(159,436,272)	(156,156,945)	(159,286,829)
Prior Period Payments	69,461,391	36,833,544	-	-
COVID-19 Enhanced FMAP	(134,650,000)	(144,644,900)	-	-
SFY21 MCO Rate Change	-	TBD	TBD	TBD
SFY22 MCO Rate Change	-	-	TBD	TBD
SFY23 MCO Rate Change	-	-	-	TBD
Total Expenditures	1,720,831,798	1,864,684,603	1,913,121,068	1,904,940,629
Ending Balance	185,521,867	70,357,446	(89,683,520)	(150,049,527)
Average FMAP				
Traditional Medicaid	63.98%	64.71%	61.75%	61.75%
Iowa Health and Wellness Plan	91.50%	90.00%	90.00%	90.00%
Average Enrollment				
Traditional Medicaid	427,797	464,008	454,633	454,633
Iowa Health and Wellness Plan	177,581	200,195	195,719	195,719

Summary of COVID-19 Enhanced FMAP Spending

Category	Amount
Projected FMAP savings	279,294,900
Spending Summary	
Funding of pre-COVID expenditures	
Recommended SFY21 pre-COVID funding level	1,572,054,926
Enacted SFY21 funding level	1,459,599,409
COVID FMAP savings used to fund pre-COVID expenditures	112,455,517
SFY20 COVID-related enrollment/expenditure increases	9,529,509
SFY21 COVID-related enrollment/expenditure increases	91,350,109
Total Enhanced FMAP Uses	213,335,135
Amount Remaining	65,959,765

Notes

The \$66.0 million remaining balance will not equal the \$70.4 million projected SFY21 surplus due to other non-COVID revenue/expenditure adjustments included in the SFY21 surplus estimate.

The amount remaining may be further reduced depending on the impact of the SFY21 MCO rate change.

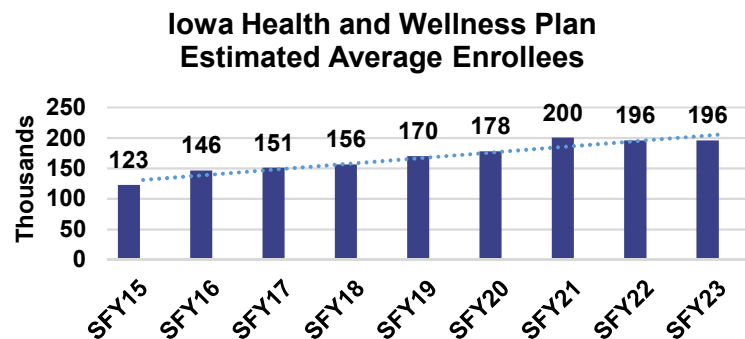
Iowa Health and Wellness Plan

DESCRIPTION

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

WHO IS HELPED

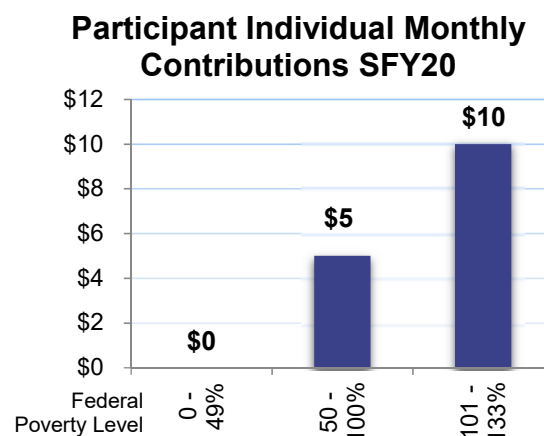
The Iowa Health and Wellness Plan expands access to health care coverage for low-income adults.



The plan covers adults, ages 19-64, who are not otherwise eligible for comprehensive Medicaid or Medicare.

COST OF SERVICES & FUNDING SOURCES

Participant financial contribution under the Iowa Health and Wellness Plan medical benefit includes features designed to encourage utilization of preventive care and overall health promotion and disease prevention through an incentive-based program.

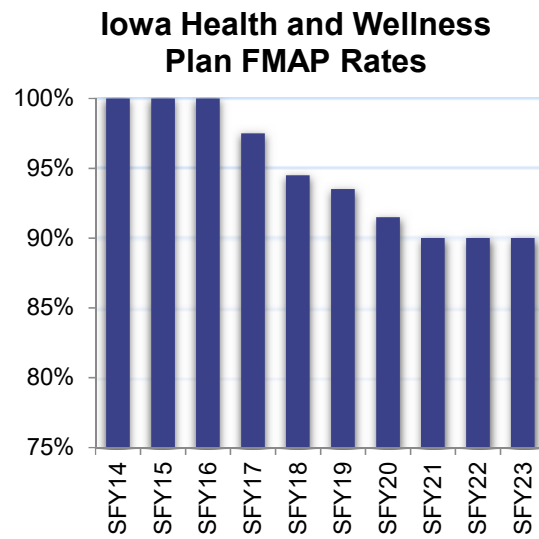


The vast majority of Health and Wellness Plan costs are reimbursed at the enhanced newly eligible Federal Medical Assistance Percentage (FMAP) under the Affordable Care Act (ACA).

Regular FMAP applies to a small portion of enrollees because they were previously eligible for other full benefit Medicaid eligibility groups.

SFY22 BUDGET DRIVERS

A primary budget driver for the IHAWP in recent years is the graduated decrease in the newly eligible FMAP from 100% to 90%.



Children's Health Insurance Program

Healthy and Well Kids in Iowa (Hawki) and Hawki Dental-Only

DESCRIPTION

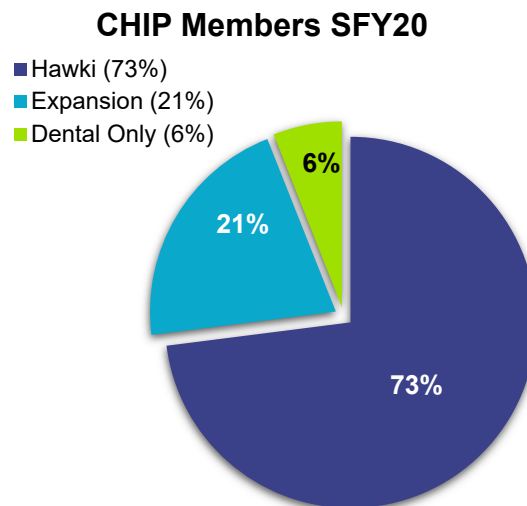
The Children's Health Insurance Program (CHIP) provides health care coverage for children and families whose family income is too high to qualify for Medicaid but too low to afford individual or work-provided health care. The purpose of CHIP is to increase the number of children with health and dental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

WHO IS HELPED

The availability of Iowa's CHIP program has been instrumental in providing coverage to thousands of uninsured children since 1998. "Iowa has one of the lowest percentages of uninsured children in the country at just over three percent. At the county-level, only one-fifth of Iowa counties have uninsured rates of more than five percent."¹

CHIP includes a Medicaid expansion eligibility group, the Hawki program, and a dental-only program.

- 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 Hawki program provides coverage for 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).
- The dental only program provides coverage to children ages 1-19 whose family income is between 167 and 302 percent of the FPL.



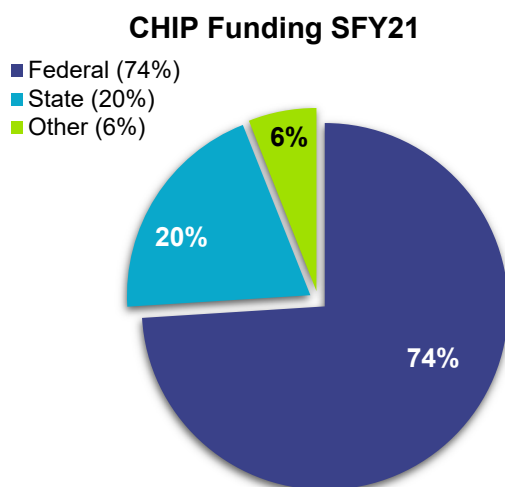
¹ <https://datacenter.kidscount.org/data/tables/9287-uninsured-children#detailed/2/any/false/1752,1712,1612,1573,1241/any/18370>

COST OF SERVICES & FUNDING SOURCES

CHIP is projected to cover 83,838 children in SFY21 at a total (federal and state) program cost of \$183.9 million.

The CHIP program is authorized and funded through Title XXI of the Social Security Act. Funding is authorized through September 30, 2023. This budget request assumes the program continues in its current form in SFY21.

- The SFY21 appropriation amount is \$37,598,984.
- In SFY21, the state share is projected at 21.82 percent; in SFY22, the state share is projected at 26.77 percent.
- Other funding projected for SFY22 includes approximately \$8.2 million in revenue from enrollee premiums, drug rebates, and other recoveries; other funding is projected at \$10.6 million in SFY22 and \$10.4 million in SFY23.



Children's Health Insurance Program

Healthy and Well Kids in Iowa (Hawki) and Hawki Dental-Only

BUDGET DRIVERS

Key factors impacting the Children's Health Insurance Program budget are provided below.

SFY20

- The year-end balance is currently projected to be \$3.4 million. The primary reason for the increase is the additional COVID-19 enhanced FMAP savings.

SFY21

- State expenditures are projected to increase significantly in SFY21. This is primarily due to COVID-19 related enrollment impacts and the phasing out of the Affordable Care Act (ACA) enhanced FMAP rates offered through the CHIP program. Most of these changes were already considered in the SFY21 enacted budget.
- The year-end balance is currently projected to be \$1.6 million. The surplus is primarily due to the extension of the COVID-19 enhanced FMAP from 9/30/2020 to 12/31/2020.
- This surplus estimate does not consider MCO capitation rate changes that will be effective January 2021. The impact of this rate change is not yet known.

SFY22

- Due to the phase-out of enhanced federal match rates, CHIP expenditures (state share) are expected to be approximately 19 percent higher in SFY22 compared to SFY21.
- This increase is compounded by a reduction in other state revenues resulting from lower prior year-carry-forward funds.
- The net result of these changes is an additional budget need of \$7.7 million.
- The SFY22 budget request is highly sensitive to the SFY21 MCO rate change.

SFY23

- Enrollment in SFY23 is expected to be similar to SFY22.
- State expenditures are expected to increase by \$1.5 million. In addition, state revenues are expected to decline primarily due to the loss of carry-forward funds.
- As a result, the total state budget need is increasing by \$3.1 million; from \$7.7 million in SFY22 to \$10.8 million in SFY23.

CHIP Financial Summary

Category	SFY20 Department Estimate	SFY21 Department Estimate	SFY22 Department Request	SFY23 Department Request
Revenue				
General Fund	19,361,132	37,598,984	37,598,984	37,598,984
Prior Year Carry-Forward	1,064,602	3,373,363	1,598,648	-
Other State Funds	1,737,294	-	-	-
Total Revenue	22,163,028	40,972,347	39,197,632	37,598,984
Expenditures				
M-CHIP Expenditures	11,122,458	12,431,313	11,389,788	11,696,248
Hawki Expenditures	36,324,307	34,153,432	34,934,334	36,078,614
Withhold/HIF	12,739	1,867,549	597,883	615,998
ACA Enhanced FMAP	(24,908,440)	(5,177,496)	-	-
COVID-19 Enhanced FMAP	(3,761,400)	(3,901,099)	-	-
SFY21 MCO Rate Change	-	TBD	TBD	TBD
SFY22 MCO Rate Change	-	-	TBD	TBD
SFY23 MCO Rate Change	-	-	-	TBD
Total Expenditures	18,789,665	39,373,699	46,922,005	48,390,860
Ending Balance	3,373,363	1,598,648	(7,724,372)	(10,791,876)
Average FMAP				
Traditional Medicaid	89.16%	78.18%	73.23%	73.23%
Average Enrollment				
M-CHIP	16,819	16,081	16,091	16,305
Hawki	57,123	61,969	63,296	63,294
Dental Only	4,606	5,788	5,812	5,836

Health Program Operations

DESCRIPTION

Health Program Operations, previously known as Medical Contracts, include those contracts that enable IME, as the federally designated single state Medicaid agency, to operate the FFS program, oversee the MCOs, and conduct operations required for the overall Medicaid program.

SERVICES

The IME is a collaboration of third party professional and system services contractors and Agency staff. The Agency's IME staff is relatively small with around 50 State employees. Agency staff provide program and policy guidance, oversight, and contract monitoring to ensure access, cost effectiveness, and quality. To support the IME structure, the Agency's contractors execute the majority of the Medicaid program business functions under a performance-based structure. The main IME contracts are:

Core Services processes all FFS claims, processes MCO capitation rates, operates systems including the Medicaid Management Information System (MMIS) and manages the mailroom operations.

Quality Improvement Organization (QIO) provides clinical support such as performs all initial Level of Care (LOC) decisions for waiver and institutional care; approves MCO recommended LOC changes and all FFS LOC reviews, provides utilization management and quality assurance for the FFS members and carries out quality assurance for both the FFS and the managed care programs.

Member Services is the State's Medicaid Managed Care enrollment broker. It provides customer services to the FFS population and provides assistance to members seeking issue resolution with the MCOs.

Pharmacy 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

Program Integrity (PI) performs provider audits and recoveries of improper payments, identifies potential fraud, waste and abuse and make referrals to law enforcement for investigations and prosecutions. PI also coordinates with other units within the Department, the Attorney General's Office, Dental Benefit Managers (DBMs), Medicaid Fraud Control Unit (MFCU), MCOs and other federal/state agencies to promote payment and program integrity. PI provides oversight of the Dental Benefits and Managed Care Entities fraud, waste and abuse programs and improper payment recoveries. In addition, PI assists in validating managed care data.

Provider Cost Audit (PCA) and Rate Setting perform rate setting, cost settlement and cost audit functions and technical assistance to both providers and MCOs. Provider rates serve as the rate floor for MCOs unless otherwise negotiated.

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

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

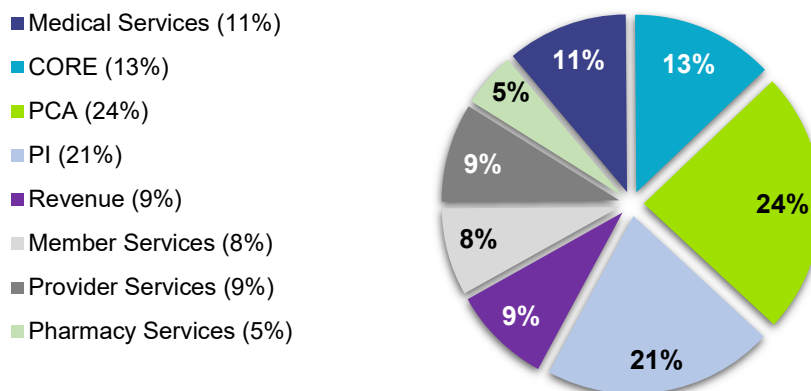
A small group of specialized vendors support the administration and operations of the managed care program. Examples include an actuarial services vendor that establishes the managed care capitation rates and assists in the review of expenditures data, and an External Quality Review Organization vendor that carries out review and quality assurance functions required by Centers for Medicare and Medicaid Services (CMS).

In addition to these contracts, the IME has a host of contracts with other state agencies and entities to provide services and activities to support Medicaid, Hawki and Iowa Health and Wellness Plan members. For example, the Iowa Department of Public Health provides Title V (maternal, child, and adolescent health) administrative services for the FFS population and overall Title V program oversight.

COST OF SERVICES & FUNDING SOURCES

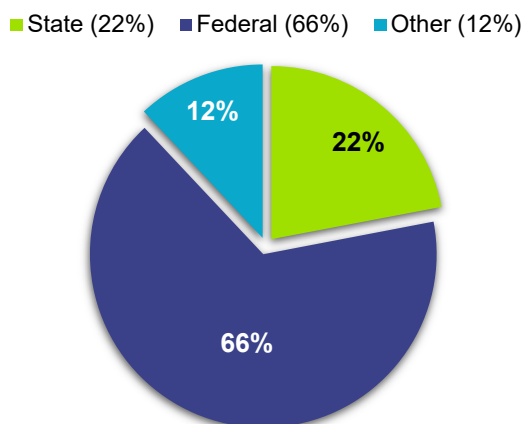
The graph below summarizes the main IME professional and systems services contracts referenced above. These contracts cover about 41% of total Health Program Operations expenditures, which is the largest section of total expenditures. The appropriation also includes Technology enhancements and Electronic Health records projects that provided enhanced funding from Centers for Medicare and Medicaid Services (CMS).

SFY21 Projected Share of State Expenditures by IME Units

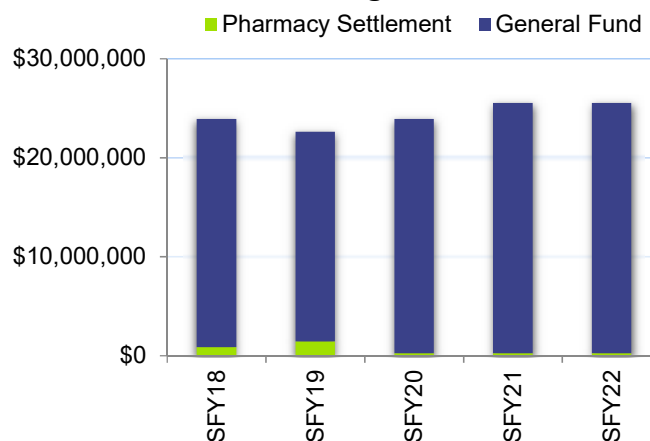


The IME Medical Contracts are funded with state and matching federal funds. The state share of funding varies for each contract ranging from 10 percent (e.g. system development), 25 percent (e.g. CORE, Medical Services, and Pharmacy POS) to 50 percent for others (e.g. Revenue Collections, PCA).

Health Program Operations Funding Share SFY21



Health Program Operations by Funding Source



State Supplementary Assistance

DESCRIPTION

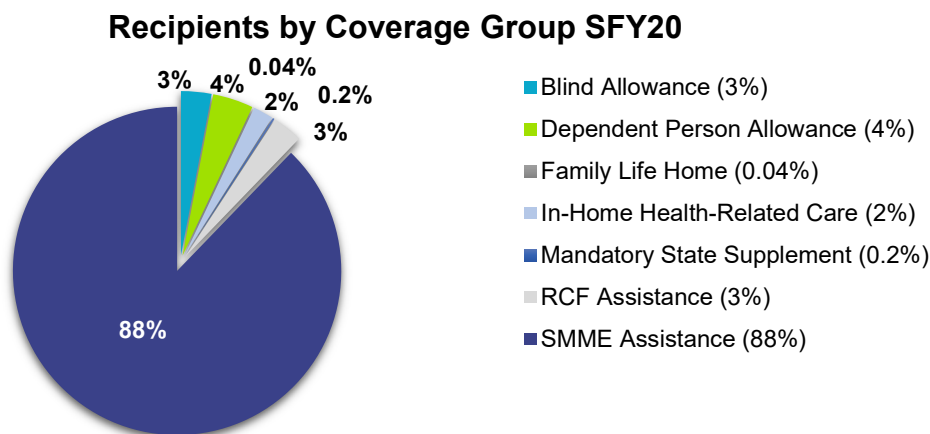
State Supplementary Assistance (SSA) helps low-income elderly or disabled Iowans meet basic needs and reduces state spending for Medicaid.

WHO IS HELPED

There are seven SSA groups (see recipients by coverage group listed with the chart below). 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.

Approximately 88 percent of SSA recipients are in the Supplement for Medicare and Medicaid Eligible (SMME) group. Providing a \$1 monthly payment to these individuals¹ saves the state money that would otherwise be paid for the individuals' Medicare Part B premiums.



May not equal 100% due to rounding.

State Supplementary Assistance provides cash payments to help meet basic needs. 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 participation amount.

COST OF SERVICES & FUNDING SOURCES

The average cost of providing SSA varies greatly between coverage groups, ranging from \$12 annually for SMME Assistance to \$5,322 for persons receiving In-Home Health-Related Care Assistance.

The total budget for SFY21 is \$10,237,612.

- \$7,349,002 (71.8 percent) of funding is from the state general fund;
- \$2,883,610 (28.2 percent) prior year carry-forward (earmarked for SNAP reinvestment activities);
- \$ 5,000 (0.05 percent) is from other funds.

¹ Payments are made quarterly.