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Legal Background Briefings are prepared and updated periodically by the Legal Services Division of the Iowa Legislative Services Agency, a nonpartisan agency providing legislative drafting and research services to the committees and members of the Iowa General Assembly. The briefings provide background information regarding a particular area of law. Although a briefing may identify issues for consideration by the General Assembly, nothing contained in a briefing should be interpreted as advocating a particular course of action. The reader is cautioned against using information contained in a briefing to draw conclusions as to the legality of a particular behavior or set of circumstances.

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Legal Background Briefing on...

IowaCare Program

Overview

This briefing provides legal background information regarding the IowaCare Program, the Medicaid expansion program for certain adults between the ages of 19 and 64 with incomes at or below 200 percent of the federal poverty level. It describes the most significant components of the program, including eligibility requirements, covered services, and cost sharing. The briefing also provides background information relating to the impetus for and development of the program. References to the Code are to the 2007 Iowa Code.

Impetus for Development of IowaCare

Joint Federal-State Medicaid Program

The Medicaid program¹ is a health insurance program jointly financed and regulated by the states and the federal government and provides medical benefits to low-income individuals who must also meet eligibility requirements relating to membership in certain covered categories such as children, parents of dependent children, pregnant women, persons with disabilities, and the elderly. The federal government has established general requirements for the program, including mandatory coverage of certain groups of individuals and certain services, but within these requirements and beyond these mandates the states are allowed a significant amount of flexibility in designing and administering their programs. Federal funding is provided to the states for eligible Medicaid expenditures based on a statutory formula linked to a state's per capita income relative to the national average per capita income. States with lower per capita incomes receive higher federal match rates, with the minimum federal match rate being 50 percent.²

States' Cost Sharing

A state's share of Medicaid costs may be paid with state or local funds, but no more than 60 percent of the state share may derive from local funds. Financing mechanisms, including intergovernmental transfers (IGTs), upper payment limits (UPLs), and disproportionate share hospital (DSH) payments have been used historically by the states to pay their share of the costs.³ Each of these financing mechanisms has been authorized by federal law or regulation. However, certain state financing strategies that combined these mechanisms in a manner which increased federal Medicaid funding above the federal matching rate, made federal matching funds available for purposes other than purchasing health care services for eligible Medicaid enrollees, inflated the overall Medicaid spending growth rates without commensurate increases in spending for Medicaid enrollees, or created incentives for states to reduce state spending for hospitals and nursing homes and replaced state funds with federal funds, drew increased federal opposition over the years.⁴

Federal Elimination of Intergovernmental Transfers

In 2004, the federal administration proposed achieving \$9.6 billion in savings over five years by restricting the use of IGTs, the Senate Budget Committee proposed a reduction in federal Medicaid spending over five years by reducing waste and abuse, the Centers for Medicare and Medicaid Services (CMS) proposed requiring states to more specifically identify revenue sources for their payment of the state share, and the Government Accounting Office recommended that Congress consider prohibiting Medicaid payments that exceeded actual costs for any government-owned facility.⁵ In 2005, CMS notified the state of Iowa that effective July 1, 2005, the state would no longer be able to use IGTs to fund Medicaid.⁶ For FY 2004-2005, the state of Iowa had four IGTs that had previously been approved by the federal government with the estimated federal

revenue to the state from these IGTs being \$67.7 million.⁷

State Reaction

Facing the imminent elimination of IGTs and the projected increases in both Medicaid costs and eligibility levels, state policymakers considered options to reform health care delivery to low-income and indigent Iowans with the goals of maximizing health care dollars while emphasizing personal responsibility and health promotion. The Department of Human Services (DHS), legislators, and the Governor's Office developed a strategy to identify state and county-only funds expended to provide health care for low-income and indigent individuals, expand the Medicaid program to a certain subset of these individuals and thereby draw down federal funds to match the state and county-only expenditures for these individuals, and make eligibility for the new Medicaid population contingent upon compliance with increased personal responsibility and wellness requirements. In addition, the strategy included other health care reform measures and goals.⁸

Funds Identified

The state and county-only funds identified included property tax dollars totaling \$34 million to provide health care to indigent individuals at Broadlawns Medical Center (BMC) in Des Moines; state dollars totaling \$27.3 million appropriated to the University of Iowa for the indigent patient or State Papers Program; and state dollars totaling \$25.9 million for the state's four mental health institutes (MHIs) for individuals not currently eligible for Medicaid or Medicare. The total of these state and county-only funds was approximately \$100 million. However, because the federal match rate under Medicaid for Iowa was 63.55 percent, only \$35 million in state matching funds would be necessary to match the approximately \$65 million in federal funds needed to equal the \$100 million in existing expenditures. This \$65 million in savings to the General Fund of the State would thereby offset the loss of

revenue to the state due to the elimination of IGTs.⁹

Medicaid Expansion Plan

Having identified the state and county-only funds, policymakers proposed that the state eliminate its IGTs, restructure the identified existing indigent care programs, and seek a Medicaid waiver for a Medicaid expansion program, named IowaCare, that would cover individuals from 19 through 64 years of age with incomes at or below 200 percent of the federal poverty level. The expansion program would have certain limitations:

- An aggregate expenditure limitation equal to the amount of funding that the state would have received under the eliminated IGTs.
- State expenditures limited to only those services for which federal matching funds were available.
- The provision of services limited to only those services currently provided to the indigent populations by the providers identified (certain inpatient and outpatient hospital services).
- A provider network limited to the safety net facilities through which the state and county-only funds had been identified (BMC, the University of Iowa Hospitals and Clinics (UIHC), and the four MHIs).
- Total enrollment limited to the funds available, thereby not creating a new entitlement.

The facilities identified as IowaCare Program providers were to be held harmless, providing these facilities with the same amount of funding as received in FY 2004-2005. Because the number of individuals projected to receive services under the IowaCare Program might not be sufficient to secure the needed matching federal Medicaid funds if only tied to eligible Medicaid services provided, the remainder of the hold-harmless funding to the participating facilities would be made up through DSH and indirect medical education payments. Payments would be made to the providers in 12 equal monthly installments based upon the appropriated amount.

Because the BMC property tax levy funds were transferred to the state to be used as the state match for the IowaCare Program, the state appropriation for the initial year of the IowaCare Program, FY 2005-2006, for BMC was \$40 million which included replacement of the \$34 million in property tax revenue, \$3 million in additional funding without any caveat attached, and an additional \$3 million in funding only if matching federal funds were available. The appropriation to UIHC and to the four MHIs equaled the amount appropriated for indigent care in FY 2004-2005.

The 1115 federal Medicaid waiver was approved July 1, 2005, for a five-year period.¹⁰

IowaCare Program Basics

Overview

Typically, the Medicaid program serves low-income individuals who fit into certain categories. In contrast, the IowaCare Program serves low-income individuals between the ages of 19 and 64 such as childless, single adults and couples, and parents of children eligible for the hawk-i program who do not fall into any of these traditional Medicaid categories.

Historical Context

While the IowaCare Program is an expansion of Medicaid to a nontraditional Medicaid population, the program also replaces the former indigent patient program, commonly referred to as the State Papers Program, and reconfigures the indigent patient care program at BMC. Additionally, the IowaCare Program does not cover all individuals without health care coverage. Those not eligible for the IowaCare Program or other third party coverage who access health care services would still be characterized as receiving uncompensated care.

Indigent Patient Care Under the State Papers Program

Under the former State Papers Program,¹¹ individuals with limited incomes who were not eligible for Medicaid were selected through a

county quota system to receive care at UIHC. The state annually appropriated a standard amount of funding to UIHC for this program. Because UIHC is a tertiary care facility, many of the individuals selected were uninsured individuals requiring high-cost procedures or medical procedures that weren't available locally through the county hospital. Another group of individuals typically receiving care through the State Papers Program were individuals with chronic conditions. The program served approximately 5,000 individuals annually and at the time of its elimination all individuals who had received care in FY 2004-2005 were sent a letter and an application form to inform them of the program's elimination and to encourage them to apply for the IowaCare Program. Those individuals receiving care under the State Papers Program who had chronic conditions, notwithstanding their income level, were included in eligibility for the IowaCare Program and continue to receive care. Because county general relief directors formerly assisted applicants for the State Papers Program, these directors were contacted and asked to provide assistance in informing consumers of the IowaCare Program and in making applications available.

Broadlawns Medical Center Community Care Program

BMC is the county hospital that by statutory obligation provides primary and secondary health care to indigent Polk County residents. A property tax levy generating approximately \$34 million is earmarked for this purpose. Prior to the creation of the IowaCare Program, the BMC Community Care Program provided care to individuals without private health insurance who were ineligible for public insurance programs such as Medicaid and had incomes at or below 500 percent of the federal poverty level, with those above 200 percent of the federal poverty level being subject to a sliding fee payment schedule. The Community Care Program was designed to provide uninsured Polk County residents with a medical home and to increase the utilization of primary and preventive care

while decreasing emergency room visits. At the time of the inception of the IowaCare Program, the Community Care Program served approximately 9,000 individuals. For individuals eligible for the IowaCare Program, BMC also continues to provide services through its Community Care Program, such as pharmaceuticals, that are not otherwise provided under the IowaCare Program.

Who is Eligible

The following individuals are eligible for the IowaCare Program:¹²

- Individuals 19 through 64 years of age, who are not eligible for coverage under the Medicaid program, who have family incomes at or below 200 percent of the federal poverty level, and who fulfill all other participation conditions, including payment of any premiums. A person who has access to group health insurance is not eligible for the program, unless the reason they are not accessing the group health insurance is recognized by rule of DHS as a legitimate excuse, which includes that it is unaffordable, preexisting conditions or exclusions apply, or needed services are not covered.
- Individuals solely eligible for family planning benefits under the Medicaid family planning waiver.
- Individuals with family incomes below 300 percent of the federal poverty level solely eligible for obstetrical and newborn care if deductions for medical expenses of all family members would reduce the family income to 200 percent of the federal poverty level or below. These individuals may receive care at any licensed hospital or health care facility, with the exception of individuals in certain counties surrounding UIHC who must receive care at UIHC.
- Individuals who received State Papers Program services for chronic health problems at the time the program was eliminated.

Eligibility must be determined by DHS staff within three working days of application. Coverage begins on the first day of the month

of application. The program allows for one-month retroactive eligibility if requested at the time of application. Eligibility is for one year and an individual must reapply annually. Those determined eligible receive an IowaCare Program card, which is similar to a private insurance card.

What Services Are Covered

The benefit package available to IowaCare Program members is less comprehensive than that available to recipients of Medicaid and the services are also limited by a provider's ability to provide the service. The services covered under the IowaCare Program include:¹³

- Inpatient hospital procedures.
- Outpatient hospital services.
- Physician and advanced registered nurse practitioner services.
- Dental services.
- Limited pharmacy benefits solely related to an appropriately billed expansion population service.
- Transportation to and from a provider.¹⁴

IowaCare Program members are also provided with a single, comprehensive medical examination, and are required to complete a personal health improvement plan and to participate in a personal health risk assessment. This is the means of developing a "medical home" for members in order to increase the quality and effectiveness of health care.¹⁵

Additionally, the program provides access to a pharmacy assistance clearinghouse program and access to a medical information hotline.¹⁶

Who Are the Providers

The providers designated under the IowaCare Program are BMC in Des Moines, UIHC in Iowa City, and the mental health institutes (MHIs) designated pursuant to Code section 226.1. Residents of Polk County may receive services at either BMC or at UIHC. Residents of other counties must receive services at UIHC. The four MHIs provide inpatient mental health services.¹⁷

What Are the Premiums and Copayments

An IowaCare Program member whose income equals or exceeds 100 percent of the federal poverty level is subject to payment of a monthly premium not to exceed one-twelfth of 5 percent of the member's annual family income. A member whose income is below 100 percent of the federal poverty level is subject to payment of a monthly premium not to exceed one-twelfth of 2 percent of the member's annual family income. A member is required to pay the monthly premium during the entire period of enrollment, but regardless of the length of a member's enrollment, the member is subject to payment of premiums for a minimum of four months. The premium payment may be reduced based upon the member's participation in wellness activities and DHS may waive the premium based upon a hardship. The premium payment amount is also reduced by the amount of any hawk-i program payments.

An IowaCare member is also subject to payment of the same copayments as an adult recipient of the Medicaid program.

In addition to the financial participation requirements, DHS is required to submit a design for an insurance cost subsidy program for the IowaCare Program members who have access to employer health insurance plans and a health care account program option for individuals eligible for enrollment in the IowaCare Program.¹⁸

How Do Individuals Apply

Applications for the IowaCare Program are available at DHS offices, online (see endnote 19), at the provider locations (BMC, UIHC, and MHIs), and at county general relief offices. Applications are sent to DHS offices for determination of eligibility.

BMC incorporated the IowaCare Program into its existing applications center and has DHS employees on-site to assist with applications and to receive premium payments. The UIHC has an IowaCare Assistance Center to assist both patients and health care providers with information about the program.

Additional Provisions of the IowaCare Legislation

The IowaCare legislation, [H.F. 841](#), 2005 Iowa Acts, also included the following requirements and components relating to rebalancing long-term care, health promotion partnerships, the Iowa Medicaid Enterprise, governance, and enhancement of the federal-state relationship:

- **Home and Community-Based Services Incentive.** Adoption of a higher level of care criteria for admission to nursing facilities than for home and community-based services in order to encourage access to home and community-based services.¹⁹
- **ICF/MR Alternatives.** Development of a plan by July 1, 2007, to enhance alternatives for individuals who would otherwise require care in intermediate care facilities for persons with mental retardation, and by January 1, 2007, development of a plan for a case-mix adjusted reimbursement for both institution-based and community-based services for persons with mental retardation or developmental disabilities.²⁰
- **Behavioral Health Care Services.** Provision of Medicaid waiver services to up to 300 children who require behavioral health care services.²¹
- **MHIs.** Expansion of Medicaid coverage for inpatient and outpatient services at the state's four MHIs.²²
- **Dietary Counseling.** Design and implementation of a strategy to provide dietary counseling and support to child and adult recipients of Medicaid and expansion population members by July 1, 2006.²³
- **Electronic Medical Records.** Development of a practical strategy for expanding utilization of electronic medical records by Medicaid providers by October 1, 2006.²⁴
- **Provider Incentives.** Design and implementation of a provider incentive payment program for Medicaid and IowaCare program providers based on

evaluation of public and private sector models.²⁵

- **Physical and Dental Health — Persons With Mental Retardation or Developmental Disabilities.** Collaboration with the University of Iowa colleges of medicine, dentistry, nursing, pharmacy, and public health and UIHC to determine whether the physical and dental health of recipients of Medicaid who are persons with mental retardation or developmental disabilities are being regularly and fully addressed and to identify barriers to such care. Report findings are due by January 1, 2007.²⁶
- **Smoking Cessation.** Collaboration with the Department of Public Health to implement a program with the goal of reducing smoking among Medicaid recipients who are children to less than 1 percent and among adult recipients of Medicaid and the IowaCare Program to less than 10 percent by July 1, 2007.²⁷
- **Dental Home.** Provision of a designated dental home for children 12 years of age and younger who are recipients of Medicaid by July 1, 2008, to provide these children with dental screenings and preventive care identified under the Early and Periodic Screening, Diagnostic, and Treatment Program.²⁸
- **Uncompensated Indigent Care.** Convening of a task force on indigent care to identify any new growth in uncompensated care due to the IowaCare Program and to identify any local funds being used to pay for uncompensated care that may be maximized through a match with federal funds.²⁹
- **Clinicians Advisory Panel.** Convening of a clinicians advisory panel to recommend to DHS clinically appropriate health care utilization management and coverage decisions for the Medicaid and IowaCare programs not otherwise addressed by the Medicaid drug utilization review commission or the Medicaid pharmaceutical and therapeutics committee.³⁰

- **Health Care Pricing and Reimbursement.** Collection of data on third-party payor rates in the state and the usual and customary charges of health care providers, including the reimbursement rates paid to Medicaid and IowaCare program providers.³¹
- **Oversight.** Provision of legislative oversight of the IowaCare and Medicaid programs through establishment of a Medical Assistance Projections and Assessment Council. The council is also to receive an annual consensus projection for the Medicaid and IowaCare programs from DHS, Department of Management, and the Legislative Services Agency joint process.³²
- **Evaluation and Audit.** Provision of a cost and quality evaluation of the Medicaid and IowaCare programs, an evaluation of the Iowa Medicaid Enterprise, and an annual federal compliance audit of the Medicaid program.³³
- **Accounts.** Creation of an account for health care transformation to be used for various health care initiatives specified and of an IowaCare Program account to be used for payments to participating IowaCare Program providers.³⁴
- **Year Five Audit.** Provision of an audit of the provisions of the IowaCare Program Code chapter by the state auditor in FY 2009-2010.³⁵
- **Repeal.** Repeal of the IowaCare Program Code chapter on June 30, 2010.³⁶

Helpful Links and Contact Information

The following internet links represent contacts to provide additional information about the IowaCare Program. In particular, the link to the Medical Assistance Projections and Assessment Council provides updates on program implementation, services, and financing.

- IowaCare application:
<http://www.ime.state.ia.us/docs/IowaCareApp.pdf>

- Iowa Medicaid Enterprise:
<http://www.ime.state.ia.us>
- IowaCare Members Services:
(515) 725-1003 or (800) 338-8366
- Broadlawns Medical Center:
(515) 282-2331
<http://www.broadlawns.org>
- University of Iowa Hospitals and Clinics:
<http://www.uihealthcare.com>
- UIHC IowaCare Assistance Center:
(319) 356-1000 or (319) 353-7381
- Medical Assistance Projections and Assessment Council:
<http://www.legis.state.ia.us/asp/committees/committee.aspx?id=70>

¹ Commonly referred to as "Title XIX" because it was created in 1965 as Title XIX of the federal Social Security Act.

² The federal match is referred to as FMAP or the federal medical assistance percentage and is adjusted annually.

³ IGTs are exchanges of public funds made between governmental entities which may include exchanges between different levels of government or between different entities at the same level of government. UPLs are the limits established by federal statute regarding the amount a state Medicaid program may pay providers for covered Medicaid services. DSH payments are payments, supplemental to the normal reimbursement hospitals would receive under Medicaid for inpatient services, to take into account the large number of Medicaid or low-income, uninsured patients that certain hospitals serve.

⁴ Kaiser Commission on Medicaid and the Uninsured, Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity, <www.kff.org>, February 2005.

⁵ Kaiser Commission on Medicaid and the Uninsured, Current Issues in Medicaid Financing — An Overview of IGTs, UPLs, and DSH, <www.kff.org>, April 2004.

⁶ Statement by Governor Vilsack, <www.governor.state.ia.us/news/index.html>, March 24, 2005.

⁷ Iowa Legislative Services Agency Fiscal Services Issue Review: Medicaid Intergovernmental Transfers, Feb. 20, 2004: \$29 million through the Hospital Trust Fund, \$7.4 million through the Senior Living Trust Fund, \$18.1 million through Supplemental Indirect Medical Education, and \$13.2 million through Supplemental Disproportionate Share Hospitals.

⁸ The purpose of the IowaCare Program is provided in Iowa Code § 249J.4: "The purpose of this chapter is to propose a variety of initiatives to increase the efficiency, quality, and effectiveness of the health care system; to increase access to appropriate health care; to provide incentives to consumers to engage in responsible health care utilization and personal health care management; to reward providers based on quality of care and improved services delivery; and to encourage the utilization of information technology, to the greatest extent possible, to reduce fragmentation and increase coordination of care and quality outcomes." See also DHS Briefing to the Iowa House of Representatives, <www.ime.state.ia.us>, April 5, 2005.

⁹ The actual state and county funds estimates and net cost were: With a total of state and county-only funds being \$89.2

million, by matching the state and county-only funds with federal dollars, the state and county savings would be \$55.2 million, which would be transferred to the Medicaid program, with a net cost to the state with the elimination of IGTs of \$12.9 million. Fiscal Services Division, Legislative Services Agency. Iowa Medicaid Reform Act, Notes on Bills and Amendments (NOBA), May 3, 2005.

¹⁰ Section 1115 of the federal Social Security Act grants the Secretary of Health and Human Services the authority to waive compliance with certain Medicaid requirements in order to authorize experimental, pilot, or demonstration projects that promote the objectives of the Medicaid statute.

¹¹ 2005 Iowa Code ch. 255A.

¹² Iowa Code § 249J.5.

¹³ Iowa Code § 249J.6.

¹⁴ Prescription pharmacy services provided as part of an inpatient hospital stay are covered and may include a 10-day, after-discharge supply. BMC's Community Care Program still provides pharmaceutical coverage and durable medical equipment to individuals with incomes at or below 200 percent of the federal poverty level. UIHC began a pilot program in August 2006 to provide generic prescription drugs and 30-day supplies of brand-name prescription drugs to IowaCare Program members if the prescriptions are written by a UIHC practitioner and filled at UIHC pharmacies. If a member requires a refill and lives outside of Johnson County, the prescription refill will be mailed. If a UIHC IowaCare Program member lives in Polk County, the member is not eligible to receive an ongoing supply of prescription drugs, but may receive a 10-day supply upon discharge from UIHC. Recipients of care under the State Papers Program grandfathered into the IowaCare Program due to a chronic medical condition which required prescription drugs also continue to be eligible for the required prescription drugs. UIHC is also providing durable medical equipment, including prosthetics, to IowaCare Program members on a pilot program basis.

¹⁵ Iowa Code § 249J.6(2) was amended by 2006 Iowa Acts, ch. 1184, § 113, to delay the implementation of these provisions until January 31, 2007.

¹⁶ Iowa Code § 249J.6.

¹⁷ Iowa Code § 249J.7.

¹⁸ Iowa Code § 249J.8. See IowaCare Application, <www.ime.state.ia.us/docs/IowaCareApp.pdf>, for premium amounts. Iowa Code § 249J.8 was amended by 2006 Iowa Acts, ch. 1184, § 115, to provide that once an IowaCare Program member pays the premium for four consecutive months in a consecutive 12-month period, the member is only subject to payment of the monthly premium on a month-to-month basis for the subsequent 12-month period of enrollment.

¹⁹ Iowa Code § 249J.11.

²⁰ Iowa Code § 249J.12.

²¹ Iowa Code § 249J.13.

²² Iowa Code § 249J.14.

²³ Iowa Code § 249J.14.

²⁴ Iowa Code § 249J.14.

²⁵ Iowa Code § 249J.14.

²⁶ Iowa Code § 249J.14.

²⁷ Iowa Code § 249J.14.

²⁸ Iowa Code § 249J.14.

²⁹ Iowa Code § 249J.15.

³⁰ Iowa Code § 249J.18.

³¹ Iowa Code § 249J.19.

³² Iowa Code § 249J.20. Originally the council was to agree to a projection for Medicaid and the IowaCare Program expenditures. This was amended by 2006 Iowa Acts, ch. 1184, § 116, to only require a review of the consensus projection.

³³ Iowa Code §§ 249J.16, 249J.17, 249J.22.

³⁴ Iowa Code §§ 249J.23, 249J.24.

³⁵ Iowa Code § 249J.26.

³⁶ Iowa Code § 249J.26.

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