MINUTES

Health Policy Oversight Committee

First Meeting of the 2021 Interim

Monday, December 20, 2021

MEMBERS PRESENT

Senator Jeff Edler, Co-chairperson
Senator Joe Bolkcom
Senator Mark Costello
Senator Mike Klimesh
Senator Amanda Ragan

Representative Joel Fry, Co-chairperson
Representative John Forbes
Representative Shannon Lundgren
Representative Ann Meyer

LSA CONTACTS: Organizational staffing and minutes provided by: Patty Funaro, Sr. Legal Counsel, 515.281.3040

CONTENTS

I. Procedural Business

The first meeting of the Health Policy Oversight Committee for the 2021 Interim was called to order at 9:00 a.m. on Monday, December 20, 2021, and was adjourned at 11:10 a.m. The meeting was held by videoconference.

II. Department of Human Services Update

Ms. Kelly Garcia, Director, Department of Human Services and Department of Public Health, provided an update on issues affecting the Department of Human Services (DHS) and Department of Public Health (DPH).

Department of Justice Report on the Resource Centers. Director Garcia began by reviewing the Department of Justice (DOJ) final report that was released on December 8, 2021, following an over two-year investigation of the Glenwood and Woodward Resource Centers (resource centers). In November of 2019, the DOJ notified DHS that the DOJ was initiating an investigation into the resource centers under the federal Civil Rights for Institutionalized Persons Act (CRIPA) and the federal Americans with Disabilities Act (ADA). Documents regarding the full timeline of the investigation and the DOJ report are available on the DHS website. The initial findings related to the Glenwood Resource Center involving the conducting of human subject experimentation without consent, inadequate physical and behavioral care and supports, and lack of quality assurance were reported on December 22, 2020. The December 8, 2021, report involved findings regarding both resource centers relating to the services available. The state was found to be in violation of the CRIPA as well as the ADA, and in general, the state was found to overutilize beds in institutional settings for persons with intellectual disabilities (ID) and developmental disabilities (DD) because Iowa lacks a full array of community services. The findings are significant and are being taken seriously, but were not surprising to DHS. The findings extend beyond state-owned facilities to include placements in privately run facilities including intermediate care facilities (ICFs), both

public and private, as well as nursing facilities and other licensed facilities that are home to persons with ID and DD. DHS has worked very closely with the DOJ for two years, has made great strides in the last 18 months even with the backdrop of the pandemic, and is well on the way to solving the issues and building out access to community services. DHS believes everyone should have the option of living in the least restrictive environment in the community. The Medicaid team including the managed care organizations (MCOs) has been involved in the community integration efforts. Prior to the committee meeting, DHS provided a copy of the DHS community integration year-one strategic plan update to the members and reviewed the plan with members individually. DHS will be building on this first-year plan moving forward with negotiations with the DOJ. DHS will meet with the DOJ on December 22, 2021, to discuss next steps in negotiating the state's consent decree. Director Garcia is still negotiating the consent decree with the DOJ relating to the specific findings from the earlier investigation of the Glenwood Resource Center, and the meeting with the DOJ, in part, will clarify whether there will be two consent decrees relating to the separate investigations, or whether the two investigations will be combined into one consent decree document. DHS will continue to negotiate in earnest regarding how the state will come into compliance. DHS is having conversations with guardians and loved ones of residents of the two resource centers, as well as team members at the resource centers about both choice in the community and a real revision of the way the resource centers are used. A significant part of the effort is focused on ensuring that those involved understand the full array of services and supports available in the community, including the role that the resource centers play.

In the findings document, the DOJ references the lack of MCO oversight. DHS agrees with this finding and spent the better part of a year reviewing the MCO contracts. Since DHS is actively involved in the procurement process of MCOs, DHS will imbed terms in the contracts that hold the MCOs accountable for serving Medicaid members with DD and ID. This is something Iowa can lead the nation in doing.

In response to a question by Co-chairperson Fry regarding whether the DOJ had considered the effect of the significant rate increases provided for home- and community-based services (HCBS) and habilitation by the General Assembly for FY 2021-2022 in expanding community capacity, Director Garcia responded that the DOJ had reviewed the rate increases but believes there is still more work to be done. DHS shares this sentiment. Director Garcia stated that, as noted in the DOJ report, the state has a significant investment on the institutional side of services. This is not just a state issue since the federal government also provides financial enhancements on the institutional side of services. There are a number of pieces of legislation being contemplated at the federal level to work to equalize the investment on the HCBS side. DHS is actively engaged in an overall assessment of the waiver structure in the state which will assist policymakers in making decisions regarding the right rate investment moving forward.

Senator Bolkcom noted that there were many concerning details in the DOJ report showing decades of neglect at the institutions. His concerns related to the Iowa Medicaid Enterprise (IME) as a whole not being able to verify MCO-reported data, the state having no plan to make sure the data is accurate and no plan to use the MCO data relating to the MCO-delegated responsibility to develop the community-based provider network, and the state not tracking or requiring MCOs to gather information to actually determine if the state has a decent provider network. The report indicates that case management providers need training, state oversight of community-based services is lacking, data quality is a concern, and there is no regular inspection of community-based residential care providers. Senator Bolkcom wondered if the state is in any position to actually determine the quality of the data for these institutions and what system is in place to ensure that expenditure data is accurate and usable. He conjectured that the state has outsourced an enormous amount of responsibility to the MCOs without any oversight of whether they are actually fulfilling their responsibilities. Because of

the DOJ report, at least regarding the residents of the resource centers, the state has been forced to take a close-up view of the deficiencies of privatization. Senator Bolkcom asked what investment is necessary to get the state back on track and assess the data from the MCOs, and whether outside assistance is needed.

Director Garcia responded that DHS has to focus on the discrete areas confirmed by the DOJ, and the governor has provided additional team members to assist the department. DHS is also in the process of updating information systems along with additional enhancements that will help with understanding what data points exist and how to use them. There is definitely a data accuracy issue, and not just in the Medicaid program. DHS computer systems are old and are hard to pull information from. At times the pulls DHS generates are inaccurate, not because the data is inaccurate, but because the systems are so cumbersome. DHS is adding data expertise in the form of additional staff as well as in enhancements to the data system itself to overcome these challenges. She reminded the committee that when the DOJ released its findings, it was based on the system that existed when the investigation was begun two years earlier. The DOJ report acknowledges that the state has made some progress, but there is still a lot of work to do. There are, absolutely, areas where DHS needs external support both at the resource centers as well as in augmenting their own team to ensure real progress. Most importantly beyond the progress that has been made, DHS has to hold steady and cannot backslide. One deficiency Director Garcia has been talking about for some time is the lack of internal expertise in the central office. It is important to have oversight and quality assurance, and to measure key data points. But it is equally important to have people dedicated to looking at the data all day, every day. DHS intends to ask for the resources to build this capacity in the agency. Director Garcia stated that she is happy to discuss these issues further, acknowledged all of the problems Senator Bolkcom identified and that the DOJ highlighted, and stated that DHS has a response plan for each of the issues.

Representative Meyer asked if addressing the waiting lists would be part of the review of the waiver programs. Director Garcia affirmed that what DHS refers to as “interest lists” rather than “waiting lists,” due to there being duplicated individuals in many of the waiver structures, is part of the assessment of the waiver structures. DHS needs to address inclusion of the appropriate array of services in each waiver, ensure the waivers are funded at the appropriate level, and then work on who is eligible for which waiver so there is a clear path for family members to access services. All of this will culminate in a deeper understanding of how many members are actually awaiting particular waiver services, which will then allow DHS to move forward with what a buydown looks like at an appropriate level. DHS is not able to do this today because there is no lens into who is duplicated across the seven waivers.

Representative Lundgren stated that she had spoken with representatives of Hills and Dales, an ICF/ID in her area, noting that these organizations are important in the community, and wondered how DHS views the private ICF/IDs as part of the service array going forward. Director Garcia responded that DHS is not looking at just one part of the system but at truly building out an array of services that is a continuum of care. For example, Hills and Dales does a phenomenal job of serving children, and children fare very well in a more structured setting. But what Hills and Dales does, and what DHS needs to do at the resource centers, is from day one, work on transitioning the person out of the resource center. Sometimes the transition takes place at a younger age and sometimes it takes place at the typical adult age of 18. The state-operated facilities lack this type of vision. DHS has been working diligently not just on an operational change, but on a cultural change, infusing that outlook back into the resource centers, so that both public and private providers help stabilize individuals and support the broader community. She provided the hub-and-spoke analogy in which the resource centers are the hub delivering the high-acuity level of care and the community providers are the spokes. It is the job of

the state to make sure the resource centers are a stabilizing force in the community, not by pitting the state facilities against the community providers, but by building out the continuum of care for everyone.

Departments of Human Services and Public Health alignment. Director Garcia noted there would be additional discussions regarding the alignment of DHS and DPH over the course of the coming weeks, but provided a high-level update. Director Garcia noted the governor had asked Director Garcia to work on aligning the two departments, and DHS contracted with a third-party vendor, Public Consulting Group (PCG) to assist in the effort. Through the course of the assessment with PCG, which involved extensive stakeholder input, it became clear that the best course of action to strengthen health and human services is to integrate the two agencies into a new single organizational structure. The goals of the new structure are to reduce fragmentation by eliminating the silos both within and across the agencies, to put like functions with like functions with a clear reporting structure, and to work on a longer-term vision of blending and braiding funding streams to maximize use of federal dollars. The alignment will work to break down cultural and structural barriers to provide a no-wrong-door entry for services for Iowans in need. It will take a system-wide integrated focus on both prevention and early intervention, and the alignment will need to ensure that important functions are not lost. Public health functions will be the cornerstone, but the alignment will also highlight, for example, what role these departments, in addition to the Department on Aging, have in supporting aging individuals. The specific structure of the new organization is not yet known, but Medicaid will serve as its backbone. The Medicaid program will have added leverage in providing health care by applying the work on disease prevention and population health to the Medicaid program which, as a major insurer in the state, can then work to drive change.

III. Medicaid Program Update — Medicaid Director Elizabeth Matney

Director Garcia expressed that as work on the realignment takes place, it is incredibly helpful to have Director Matney back. There was a wonderful pool of applicants for the Medicaid director position,

including former Medicaid directors, but no one matched Director Matney's passion for the program, for its members, for the technical aspects, for thinking about how to align Medicaid as a backbone of the combined departments, and to drive change.

DOJ Report and Medicaid. Referencing the "Medicaid-specific priorities from DOJ report" document, Director Matney began by noting that there were three primary themes or pieces pertaining to Medicaid in the DOJ report.

The first piece is assessing services, including assessing the provider network and the continuum of services available today. The Medicaid team has been working on a way to assess the full array of services including disability services, behavioral health services, and aging services. One of the opportunities presented by the federal American Rescue Plan is the opportunity to submit an enhanced funding plan to receive additional federal funds for community-based services. One part of the state's enhanced funding plan is performance of a full-scale assessment. The contract to perform the assessment was awarded to Mathematica and work is scheduled to begin in January 2022. The assessment will be performed over the course of one year and will include quantitative as well as qualitative analyses, and interviews of Medicaid members and their families, providers, and other stakeholders. She expects fulsome recommendations to come out of the assessment on how to change the waiver structure, how to build the provider network and fill gaps in services, and how to better align care coordination across different services and touchpoints. Near term, the contract has been awarded, longer term the recommendations from the assessment report will be implemented.

The second piece is ensuring seamless care coordination. The DOJ report discussed informed person-centered planning. This requires ensuring that an individual has a clear line of sight as to who is taking the lead on their care coordination and that roles and responsibilities are clearly identified within the agency and the MCOs. Near term, the Medicaid program is actively engaging members

and stakeholders in town hall meetings to determine what is and is not working. These discussions will inform project planning as well. Long term, the recommendations of these town hall meetings will be implemented.

The third piece is the transparency and accountability to which Senator Bolkcom referred. Medicaid collects a lot of data today with the intention to provide for robust oversight of the managed care system. The data validation piece is tricky because of the limitations of the state's older legacy computer system. It will take time to modernize the system, but in the meantime the Medicaid team is figuring out ways to mitigate the real concerns about validation of data. Due diligence is necessary to ensure that the data reported is accurate and when issues are identified in the data that there is follow-up on all fronts to remedy the problem or develop a plan to correct it. The Medicaid team is inventorying the data, assessing gaps in the data collected, and clearly defining the roles and responsibilities for the oversight functions. One bureau cannot provide all of the oversight for Medicaid data, because much of the data comes in through different bureaus. The data is then disseminated to different policy experts to review and analyze for accuracy and to then determine next steps with the MCOs. Longer term, the Medicaid team would like to set up a public dashboard for long-term services and supports (LTSS) to not only communicate with Medicaid members but with providers, legislators, and stakeholders about how the Medicaid program is performing. It is important to have input not only on what metrics are used but on how the data is reported. The Medicaid team is also updating the MCO contracts as part of the request for proposals (RFP) process to move from a focus on compliance to a focus on outcomes, and to weave in expectations around community integration.

In response to a question by Co-chairperson Fry about whether DHS has used the MCO capitation payments to incentivize community placement rather than resource center placement, Director Matney responded that the way the capitation payments are structured and blended should provide some

incentive for community placement. However, all options are open for discussion and she asked that anyone with ideas for improving incentives discuss them with her. Moving forward there will be more safeguards attached to payments to ensure the desired outcomes related to community integration are realized. Senator Bolkcom asked if the contract with Mathematica is an effort to improve data verification. Director Matney responded that DHS entered a multiyear contract with a $10 million ceiling with the intention of using the same contractor throughout the process to provide for consistency. The first component is the system assessment with the outputs being identification of program gaps, recommendations on structuring services and waivers differently to provide equity across the waivers in terms of service and access, and identification of mechanisms for more streamlined care coordination. The contract provides for an additional three years for Mathematica to assist with implementation to avoid having to hire a whole new team of staff to implement the recommendations from the underlying work. Mathematica is subcontracting with the Harkin Institute to facilitate focus groups and interview work because the Harkin Institute already has connections in the community and provides a valuable partner in the state.

Senator Bolkcom asked what role DHS is playing to put a plan in place and build out community services, noting that it takes both financial and workforce resources to do so. Director Matney agreed and responded that earlier in the year, Marissa Eyanson, Administrator, Division of Community Mental Health and Disability Services, and Director Matney conducted approximately six community integration town hall meetings to talk about the progress that had been made on the community integration strategic plan. Many Medicaid members and those who depend on community-based services responded, and much of the feedback was that expanding services and provider capacity would be very challenging without increasing the hourly wage for direct service professionals. While the rate increases for HCBS and habilitation providers for FY 2021-2022 did help, the general feedback

is that more needs to be done. Director Garcia alluded to this as well. Money is part of the issue to be able to retain the workers DHS has as well as attract additional workers into this workforce pool, but there is also a need to talk about how to market this profession so people know it exists and know what a rewarding profession it is and has been for many Iowans for decades. DHS is working with other state agencies to make sure community-based services employers know that programs, like the registered apprentice program, are available, and they are working with other associations to develop marketing campaigns. A groundswell of enthusiasm needs to be created around this type of work in combination with enhanced training and education opportunities, fair and competitive wages, and generally creating a positive culture for this workforce.

Iowa Medicaid Strategic Plan. Director Matney noted that when she returned to the Medicaid program in June 2021, she began by working with her team to identify its mission, vision, and shared values as a basis for developing a strategic plan. The strategic plan has four key objectives: identifying and mitigating program gaps in meaningful service delivery; shifting program operations and planning to focus on outcomes; promoting transparency in program development and performance; and modernizing the Medicaid infrastructure and operations. The mission underlying the four objectives is centered on ensuring all members have equitable access to high-quality services that promote dignity, that barriers are removed to increase health engagement, and that whole-person health is improved across populations.

Focusing on identifying and mitigating program gaps, Director Matney provided the following examples of the Medicaid team's response to the DOJ report: entering the contract with Mathematica; assessing disability, behavioral health, and aging services; putting together a Medicaid maternal health plan working closely with DPH and others to make it cohesive; and identifying and mitigating health disparities and utilization gaps across the state.

Regarding the objective of shifting program operations and planning to focus on outcomes, Director Matney stated that Medicaid is such a law-and-rules-heavy program that sometimes the focus is not on the overall outcomes for members. The shift is not just in including outcomes in MCO contracts, but changing how the Medicaid team thinks about day-to-day business. With regard to promoting transparency, Director Matney stated that this objective is particularly important to her personally and why it is so important to implement member and provider town halls. People directly involved need to be imbedded in program design and implementation with a real-time feedback loop. If not, even though programs are implemented with the best of intentions, they might not work out in reality. The Medicaid team wants the real-world, boots-on-the-ground perspective imbedded into everything they do. Modernizing Medicaid infrastructure and operations has many facets. One approach is looking at how they do business from start to finish. One of the first areas the team tackled is on the provider side by reviewing processes that are duplicative or cumbersome, including provider enrollment. They have suggested a number of proposed outcomes in a provider survey to get provider feedback and collect baseline data on how difficult it is for providers to enroll in Medicaid and become credentialed through the MCOs, as well as other aspects of being a provider, such as claims processing. Modernization also focuses on how often provider reimbursement rates are reviewed and updated. Currently, rates are only reviewed if DHS is required to do so by the General Assembly or their federal partners. But, there are a number of providers whose rates have not been regularly reviewed or updated in up to a decade. The team is imbedding an annual review of all rates in their processes and providing access to this information to the public.

Director Matney has been conducting town halls with members and providers, but has also been meeting with MCO presidents and other individuals to understand obstacles in the system to moving forward with changes. Some of the themes from the meetings and areas where additional subgroup work will

be done is in the areas of HCBS consumer choices option, provider administrative burden, the health and disability waiver, and transportation.

The Medicaid team will be hosting listening sessions in January and February 2022 to understand how things are working in areas such as durable medical equipment, school-based services, the prior authorization process, provider enrollment credentialing, case management, maternal health, and the reliance on natural supports.

Director Matney reported that the Centers for Medicare and Medicaid services of the Department of Health and Human Services (CMS) fully approved the enhanced HCBS spending plan on December 16, 2021, funded through the federal American Rescue Plan. Work on several projects is underway in three primary areas: provider training, expanding access, and supporting the workforce. Within these three areas there are fourteen projects. A lot of work will be happening in a tiered manner spread over the resources available. The Medicaid team had begun work even before receiving full federal approval of the assessment for behavioral health, disability, and aging services that was built under this enhanced spending plan. The Medicaid team is also releasing funds to help providers with retention and recruitment bonuses. The team began having some pediatric community neuro-restorative services pilot listening sessions in November. The state has community neuro-restorative services for adults but not for the pediatric population, which results in a number of children going out of state for services.

After the first of the year, the team will kick off a number of other projects. The HCBS spending plan is posted on the Medicaid website.

SFY 2022 MCO Contracts. Director Matney stated that DHS is still waiting for federal approval of the latest MCO contract changes from CMS. The total capitation rate increase of $153 million in state and federal funding is based on overall enrollment distribution. A portion of the increase in the capitation rate

is a result of an increase in appropriations by the General Assembly. Director Matney reviewed some of the legislative appropriations reflected in the MCO contracts including rate increases for psychiatric medical institutions for children (PMICs), HCBS services for certain tiers, the pharmacy dispensing fee, air ambulance, and the home health agency low-utilization payment adjustment. She noted there are still children on the PMIC waiting lists.

MCO RFP Timeline. Director Matney reported that DHS intends to release an RFP in the winter of 2021-2022, more likely in 2022, to procure the most qualified MCOs. The RFP is necessary because Amerigroup's contract ends in June 2023 and the contract must go out for bid. The scope of work was tightened up, especially with regard to LTSS and oversight. The deadline for bid proposals is summer 2022; DHS will award the contract(s) and begin onboarding with the MCO(s) in the fall of 2022; there will be an MCO readiness review in the spring of 2023; and MCO operations will begin in July 2023. Town hall participants have expressed frustration with not being included in the contract process and in the development and thinking around the MCO contracting and procuring in the past, so DHS will be adding a listening session in January to obtain input from stakeholders on changes they would like to see in MCO contracting and procurement moving forward.

Iowa Total Care (ITC) Withhold. Director Matney provided an update on the ITC withhold. She reported that in January 2020, DHS withheld $44 million from ITC due to multiple payment issues with providers. The withhold was calculated based on a methodology, taking into account the number of outstanding claims and the number of months ITC failed to correct the issue. DHS contracted with Myers and Stauffer to provide an independent review of the issues. There were two phases to the independent review, with completion of the review in March 2021. Withheld funds were then released to ITC in February, March, and April 2021, as issues were resolved. DHS continues to monitor both MCOs for claims issues, but this particular corrective action process is now closed.

Unwinding the Public Health Emergency (PHE). Director Matney noted there are rules for Medicaid related to the PHE and the maintenance of effort (MOE) for the Medicaid and hawk-i programs. CMS has released guidance in phases to resume normal eligibility processes. Phases 1 through 3 have been implemented and the final phase will begin when the federal PHE declaration ends or when the PHE and the eligibility provisions are decoupled. During phase 1 earlier this year, some regular day-to-day Medicaid eligibility processes that did not require technical assistance and were not subject to MOE requirements were resumed, such as those for individuals who were approved in error. These individuals were transitioned to other coverage groups. During phase 1, DHS also began reviewing eligibility for hawk-i members who had aged out of coverage by turning 19 years of age. If these individuals could be moved to the Iowa Health and Wellness Plan, DHS enrolled them in that program to maintain coverage.

During phase 2, DHS resumed some of the automated eligibility redeterminations that were not subject to MOE; for example, when a household reported a change in circumstances. DHS also transitioned members who were no longer eligible for LTSS to another Medicaid coverage group based on level of care assessments or because their income had changed significantly. DHS also began completing renewals when there were household or LTSS changes.

In phase 3, DHS resumed issuing annual renewal forms to some targeted households, updated the DHS website to include unwinding plan information, and started issuing PHE ineligibility letters to members. However, issuance of these letters was discontinued after a new state health official letter from CMS was released on August 13, 2021, that disallowed the use of these letters. Issuance of these letters is paused until the PHE ends or a date for issuance is established by CMS.

For the final phase, DHS will resume all regular Medicaid eligibility processes, including discontinuances. CMS requires completion of a redetermination of eligibility for Medicaid members after the PHE ends, with the priority being processing households that include someone who was found ineligible during the

PHE but whose eligibility was maintained due to the MOE, and then focusing on the remaining Medicaid population. This phase also includes reinitiating member premiums and cost sharing for applicable members after the PHE ends.

Additional flexibilities were instituted in the Medicaid program resulting from the response to COVID-19. Iowa Medicaid has several waivers and state plan amendments (SPAs) in place to ensure continuous and expanded services for Medicaid members. Some examples are: providing home-delivered meals to all members who are homebound who normally would not qualify; reimbursing family members for services they are providing because they were not able to hire other personal care providers in their community; and allowing for services such as respite while caregivers are working. When thinking about these flexibilities, it is important to consider that care has to be provided in a person-centered way, focusing on a member's needs and preferences. A key example is the option of virtual vs. face-to-face case management. The virtual option has been critically important during the pandemic but there are advantages to meeting face-to-face such as the opportunity for a provider to do an environmental scan and assist with paperwork. If a Medicaid member prefers and everyone is safe in doing so, face-to-face meetings can continue. This also applies to telehealth. Expanded telehealth codes may be recommended post-PHE. On the behavioral health side, a broad number of telehealth codes have been implemented for sites of service and coverage. However, in other areas there are recommendations from providers, members, and other stakeholders that although telehealth is better than nothing, depending on an individual's needs and preferences, the outcome and experience of telehealth has not been as effective as in-person services. Telehealth has been a life saver, but it is an area DHS will continue to monitor to ensure members are still getting what they need.

IV. MCO Performance

Director Matney reviewed the unaudited medical loss ratio (MLR) for both MCOs, with Amerigroup's MLR being 88.1 percent and ITC's MLR being 92.3 percent. There has been a lot of talk about consumers not utilizing health care in the same way during the pandemic, but there are areas where insurance companies have seen an increase in utilization. On the Medicaid side there has been a fairly consistent MLR. What is unique about Medicaid is that there have been a number of additional services allowed during the PHE that have offset some of the other services that were not utilized as heavily as usual. Also, with Medicaid, the highest user of services is the LTSS population. This population's utilization does not change even during a pandemic. Medicaid did see a dip in well-child visits nationwide. This prompted a request from CMS to encourage families with children to go in for their annual visits as well as their immunizations. Medicaid is also keeping an eye on decreases in preventive visits.

Director Matney noted that the MCO performance report now includes a children's summary. The team also added a section showing the top five services in utilization by waiver. This helps to plan for the future if noticeable gaps in services are detected.

Co-chairperson Fry asked how many Medicaid members DHS projected would be disenrolled post-PHE. Director Matney stated that it is a moving target, but her recollection was that it was about 50,000. She said DHS would be publishing a dashboard in 2022 with a number of data points on enrollment, eligibility, and redeterminations so that everyone can see where DHS is in the review process as they start to unwind the PHE. As to when the PHE might come to an end, Director Matney noted the Congressional Budget Office had priced the PHE-enhanced federal Medicaid assistance percentage (FMAP) through June 2022, but she has also heard other projections. In the federal Build Back Better Act, the PHE was decoupled from the enhanced FMAP so states could assume the enhanced FMAP would go on through calendar year 2022 and states could begin doing disenrollments in April 2022 progressively throughout

the year. In response to a question by Co-chairperson Fry as to whether DHS anticipated needing any legislation to help with the disenrollment, Director Matney responded that she did not foresee needing any legislation. Co-chairperson Fry asked if Amerigroup succeeded in meeting the MLR of 89 percent and when the audit of Amerigroup's MLR would be completed. Director Matney responded that she would provide answers to both questions to the committee following the meeting.

Senator Bolkcom asked if the number of Medicaid members who have been vaccinated is being tracked and if the number of hospitalizations of those who are not vaccinated and the expense of these hospitalizations to taxpayers is being tracked. Director Matney responded that DHS is collecting vaccination numbers. Collecting the data has not been easy because the provider might not always bill Medicaid for the vaccination, and she fears the data is incomplete. As far as the costs to the Medicaid program related to COVID-19, she stated that it is an interesting case study. Medicaid is not tracking the costs based on whether a person has or has not been vaccinated. Senator Bolkcom reiterated that his concern is the cost to taxpayers related to those who have not been vaccinated and require medical care. He also reiterated that, given the DOJ finding that the state is not verifying the data collected from the MCOs, and the fact that the state hired outside assistance in responding to the ITC dispute, he wondered if the data the state has is reliable. Director Matney clarified that ITC paid for the outside assistance provided related to the ITC withhold. Senator Bolkcom asked Director Matney to respond to the issue of the health care system being able to provide for Medicaid members given the repeated surges in COVID-19 cases. Director Matney responded that the workforce in general is concerning to her, and has been the most concerning aspect of her position for the past several months. The workforce issue is not limited to hospitals, which have at least received some additional funding from federal partners, none of which is enough for the heroic work they are doing. She is more concerned about the HCBS workforce, which is stretched very thin, is straining under the emotional and physical

toll, is burned out, and is relying on family members to provide support. It will take a lot of people at the table to come up with a long-term sustainable workforce plan and Medicaid wants to be at the table.

Co-chairperson Edler suggested the same data regarding costs of hospitalizations should be collected for those who have been vaccinated.

V. Medicaid Budget

Mr. Joe Havig, Bureau Chief, Bureau of Budget and Planning, DHS, reviewed the Medicaid projections for FY 2023 based on the document entitled "Iowa Department of Human Services Budget Presentation." He noted that on page 2, the top portion demonstrates the estimates from the most recent Medicaid forecasting meeting in late October 2021, and was based on the assumption that the enhanced FMAP would remain available through the end of December 2021. At that time, the Medicaid surplus for FY 2022 was projected to be $217 million and the FY 2023 surplus was projected to be $150 million. Since then, the PHE has been extended an additional quarter, and as a result the enhanced FMAP will remain available until at least the end of March 2022. The forecasting group has not met since the PHE was extended but is scheduled to meet on December 22, 2021. In anticipation of that meeting, the group developed preliminary projections based on the extension of a Medicaid surplus for FY 2022, as shown on the bottom of page 2, of $254 million and for FY 2023 of $175 million. The amounts are due to the savings from the increased FMAP during the PHE being greater than the cost increases from the Medicaid MOE and the fact that DHS has not been disenrolling Medicaid members. These balances are tied to the PHE so are temporary. The balances will be declining and will be eliminated when the PHE ends.

Page 3 of the document provides trends for expenditures in years beyond FY 2023. The numbers assume a trend rate of an increase in costs of 1.5 percent in FY 2023 because some increase is already built into that year and 3 percent in FY 2024-2027. With those assumptions, the chart shows that the

temporary balances that the state is experiencing will be exhausted by FY 2025 and then there will be no prior year carryforwards to help with the shortfall to fund the Medicaid program. When that occurs, based on this scenario, the projections group is estimating the general fund backfill needed to make up the shortfall and fully fund the Medicaid program will be $206 million in FY 2025, $60 million in FY 2026, and $62 million in FY 2027.

Page 4 of the document provides projection scenarios for the hawk-i program similar to that for the Medicaid program. Based on the October forecasting meeting, the group projected a surplus of $1.8 million for FY 2022 and a shortfall and general fund need of $6.8 million for FY 2023. Based on extending the enhanced FMAP until March 2022, the projections improve with a projected surplus of $3.7 million for FY 2022 and a shortfall or general fund need of $5.3 million for FY 2023.

The remaining pages of the handout provide more detail behind the assumptions. Page 5 provides a visual representation of Medicaid enrollment trends through June 2023, based on the PHE ending in March 2022. Medicaid enrollment has increased since the beginning of the PHE due to the disenrollment suspension, and this increase is expected to continue until the PHE ends and while the MOE remains in effect. The information on the slide assumes that redeterminations will begin again in April 2022 and that it will take about six months to cycle through the redetermination backlog, at which point a new Medicaid enrollment baseline will be established. There is a lot of uncertainty around the timing and the degree to which the disenrollments will occur. Mr. Havig noted that the document assumes that approximately 90,000 members will be disenrolled from the program in the six-month period beginning in April 2022, but as Director Matney noted, there is a lot of fluctuation in those numbers.

Page 6 of the document is a chart showing Children's Health Insurance Program (CHIP) enrollment trends. Unlike the Medicaid trends, CHIP enrollment has remained fairly steady during the PHE. The main reason for this is because a primary pathway to CHIP eligibility is members who are determined

to be over income for Medicaid, are disenrolled from Medicaid, and move to the CHIP program. Since those determinations are not being made and Medicaid disenrollments are not occurring, those children are instead remaining on Medicaid. As a result, CHIP enrollment has been relatively flat. When the PHE ends and the Medicaid disenrollments occur, a corresponding increase in the CHIP enrollment as the higher income children shift is expected.

Page 7 of the document includes an analysis of the cost per Medicaid enrollee, demonstrating how the Medicaid member profile has changed during the PHE. The top box shows membership by eligibility type prior to the PHE in February 2020, and paying at current capitation costs shows that the population would cost $429 million today. The second box shows the same data based on PHE enrollment in October 2021. This box shows that enrollment has increased from 581,000 in February 2020 to almost 700,000 in October 2021. Due to this increase, the costs have also increased. The third box shows that the percent change in eligibility and costs have not changed uniformly across all Medicaid eligibility groups. The majority of the increased enrollment has occurred in the child, parents and caretakers, and Iowa health and wellness plan sectors. Looking at per member per month costs, these are the least costly members. For the most expensive members, those in LTSS institutional or home-and-community settings, enrollment has actually declined. The most significant decline has been in the institutional LTSS population. Because the membership profile has shifted and a greater percentage of the increased membership is in the relatively less expensive categories, it has driven down the average cost per enrollee across the entire program. While total enrollment is up by 20 percent, because of the shift in population, the average cost per member per month has declined by 9.2 percent, resulting in the total cost increase being much less than the overall membership increase. This too is driving some of the balances in the Medicaid program. The savings from the enhanced FMAP has outpaced the cost growth during the PHE and one primary reason is the shift in the population.

Mr. Havig reiterated that the Medicaid forecasting group would be meeting on December 22, so the forecast numbers may change, although probably not significantly. Director Matney also noted that the assumptions of the federal Build Back Better reconciliation bill are not incorporated into the projections. If the federal legislation passes, the group will update the projections based on those assumptions.

In response to a question by Co-chairperson Fry, Mr. Havig confirmed that there would be a $220 million general fund need in FY 2025 for the Medicaid program. Co-chairperson Fry asked if Mr. Havig had any thoughts about how to meet that need. Mr. Havig responded that they could review options but he did not have any suggestions at this time. Co-chairperson Fry suggested this issue be kept front and center during budget discussions during the legislative session. Director Matney stated that for FY 2021 and FY 2022, instead of the General Assembly providing a supplemental appropriation for the Medicaid program, the decision was made to use some of the enhanced FMAP to cover the increased need in the Medicaid program, moving the general fund supplemental need out a few years. She reminded the committee that this is a need that has been known for a couple of years.

Senator Bolkcom asked what the source is for the 6.2 percent enhanced FMAP. Director Matney stated it was the federal Families First Coronavirus Recovery Act. Senator Bolkcom offered that as to the question of where the state money is going to come from to fund the Medicaid supplemental need, the money is available in the surplus in the taxpayer trust fund which holds $2 billion. This money can be used to make sure the state has a strong Medicaid program. Co-chairperson Fry responded that he and Senator Bolkcom have a difference of opinion about budgeting and one-time needs versus ongoing expenses.

VI. Public Comment

Ms. Shelly Chandler, Iowa Association of Community Providers (IACP), thanked Directors Garcia and Matney for working with the IACP and other stakeholders during the pandemic and through the DOJ

process. She stated that while she appreciates the FY 2021-2022 rate increase for HCBS providers, the increase equated to a $1 increase in wages, while wages increased by $3 in other service industries and inflation increased by 6 percent during the same period. She suggested that the state needs to revise how HCBS is provided in the state, and thanked all of the community providers who continued to provide services during the pandemic.

VII. Materials Filed with the Legislative Services Agency

The following materials listed were distributed at or in connection with the meeting and are filed with the Legislative Services Agency. The materials may be accessed from the link on the committee's website www.legis.iowa.gov/committees/meetings/documents?committee=24165&ga=ALL

1. Department of Justice (DOJ) Findings at the State Resource Centers as of December 17, 2021, submitted by the Department of Human Services (DHS)
2. Community Integration Strategic Plan Year 1, submitted by DHS
3. Iowa Medicaid Mission, Vision, Objectives Chart, submitted by DHS
4. Iowa Medicaid Program Updates, submitted by DHS
5. Iowa Department of Human Services Budget Presentation, submitted by DHS
6. SFY 2022 Rate Summary with Legislative Changes, submitted by DHS