REPORT OF THE

MEDICAID STUDY COMMITTEE

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Interim Report

NOTE: This report was adopted by the Legislative Council as submitted.

House Concurrent Resolution 29 of the Sixty-third General Assembly, adopted at the 1969 session, directed that the Legislative Council "conduct a legislative review and study" of Iowa's Medicaid Program. The resolution directed that the review and study extend to "means of processing and paying claims for assistance, the means by which the eligibility of applicants is determined, the justifiability of charges made by vendors for supplies and services under the program, possible revision of the eligibility requirements, and such other areas as the study committee may desire". Accordingly, the Medicaid Study Committee was established and, at its organizational meeting on July 30, 1969, Representative Joan Lipsky of Cedar Rapids was elected Chairman and Representative Charles P. Miller of Burlington was elected Vice Chairman of the Committee. Other legislators serving on the Committee are Senators Minnette Doderer of Iowa City, Ernest Kosek of Cedar Rapids, J. Leslie Leonard of Linn Grove, William Palmer of Des Moines, Marvin Smith of Paullina, and Richard L. Stephens of Crawfordsville, and Representatives A. June Franklin of Des Moines, James T. Klein of Lake Mills, Clair Strand of Grinnell, and Donald E. Voorhees of Waterloo.

As of December 4, 1969, the Study Committee has held five meetings, two of which were two-day meetings. In the course of these meetings, testimony has been taken from representatives of the Midwest Regional Office of the United States Department of Health, Education, and Welfare; the Commissioner and Deputy Commissioner of the Department of Social Services and Director and staff of the Department's Bureau of Medical Services; county social welfare directors and workers; professional associations representing vendor groups involved in providing health care services and supplies under the Medicaid program, as well as individual practitioners from most of these groups; and officials of Blue Cross-Blue Shield (the state's private fiscal agent for the Medicaid program) and of two other firms writing private group health insurance contracts*. A subcommittee (Representative Voorhees, Chairman, Senator Stephens and Representative Franklin) was appointed to review a random sample of Medicaid cases selected by them personally, and to contact the recipients involved in these cases to ascertain their views of the Medicaid program.

The present interim report, which has been prepared in response to the request of the Legislative Council for submission

*See Appendix I for complete list of individuals who have participated in Medicaid Study Committee meetings.

of study committee reports by December 16, 1969, contains several preliminary recommendations. House Concurrent Resolution 29 provides that the Study Committee shall make its final report by March 1, 1970. As will be explained subsequently in this report, the Medicaid program presently faces a potential financial problem of considerable, but as yet uncertain, dimensions due to a recent federal court decision. It is hoped that the status and needs of the program can be ascertained more exactly on or before March 1, 1970.

Historical Background

The program commonly known as Medicaid was enacted by Congress simultaneously with the Medicare program, in 1965. Together, these related but quite different programs are the most recent major additions to the Social Security Act first passed in 1935.

Medicare--Title XVIII of the Social Security Act--is a two-part medical insurance program for all persons 65 years of age or older. Part A provides for payment of most costs of care in hospitals or related health facilities from funds raised by employer-employee contributions. Under Part B, most costs of doctors' care and of certain other health services are covered through monthly insurance premiums paid by or for Medicare participants and matched by a federal contribution. Medicare is operated directly by the federal government.

Medicaid--Title XIX of the Social Security Act--is a commitment by the federal government to bear a substantial portion of the cost to any state which elects to provide some or all of an array of hospital, doctor's, and other specified health services and supplies to persons who would find it difficult or impossible to pay for such services themselves. Implementation of Medicaid by the states is optional. The range of services provided under the program may vary considerably from state to state.

Prior Welfare Medical Provisions

The Social Security Act of 1935 included provisions for the federal government to participate financially with the states in providing monetary assistance to three specific categories of needy persons, the elderly, the blind, and families with dependent children. A fourth assistance category, permanently and totally disabled persons, was later added.

Originally, the cost of needed medical care was taken into account only as one factor in computing the individual recipient's assistance grants under each of the four categories. Beginning in 1950 "vendor payments"--payments by states directly to individuals or institutions providing health services to welfare recipients--were also authorized by federal law. Most of the states have made use of this authority. However, there

was a lack of uniformity in the health care benefits available to needy persons within each of the four categories.

With the passage of the Medical Assistance to the Aged, or "Kerr-Mills", Act in 1960, Congress in effect set up another welfare category, the "medically needy" aged. This category was composed of persons over 65 years of age with resources sufficient to make them ineligible for Old Age Assistance but not sufficient to pay for needed medical care. Federal aid was provided for states which established medical assistance programs to meet the needs of these persons.

The Advent of Medicaid

The enactment of Medicaid by Congress in 1965 provided a framework within which states could, with federal financial participation, greatly expand medical assistance programs benefiting both categorical welfare program recipients and various groups of "medically needy" persons, rather than just those over 65 years of age. States which establish Medicaid programs thereby replace both the Kerr-Mills medical assistance to the aged program and the separate medical aid provisions of Old Age Assistance, Aid to the Blind, Aid to Families with Dependent Children, and Aid to the Permanently and Totally Disabled programs.

Iowa's Medicaid Law

Medicaid has been implemented in Iowa under authority of the Medical Assistance Act, which appears as Chapter 223, Acts of the Sixty-second General Assembly (1967). Administration of Medicaid in Iowa was delegated to the State Board of Social Welfare, and thus passed automatically to the new Department of Social Services when that Department officially came into existence in 1968.

In contrast to Iowa's Medical Assistance Act, which is relatively short and easily read, Title XIX of the Social Security Act (the federal Medicaid law) is rather lengthy and contains numerous requirements for and restrictions upon states which implement Medicaid, and these are interpreted and carried into effect by numerous federal regulations. It is neither necessary nor possible to undertake a detailed explanation of the Medicaid laws and regulations in this report, but in order to properly evaluate the problems Iowa's Medicaid program is presently facing, a few of the key requirements must be outlined in some detail.

I. - Eligibility

The federal law requires that each state establishing

a Medicaid program must extend its benefits equally* to all residents of the state who are receiving cash payments under any federally-aided categorical welfare program. In Iowa, therefore, the minimum group of persons eligible for Medicaid benefits are the recipients of old age assistance, blind assistance, aid to dependent children, and aid to the permanently and totally disabled and some dependents of such recipients. (Actually, due to technicalities of federal and state law, the state must also make Medicaid benefits available to certain persons not presently eligible for one of the aforementioned programs, but who could be made eligible under existing federal law by changes in state law.)

In addition, a state may also include in its Medicaid program, at its discretion, all or any one of certain other groups of needy or "medically needy" persons specified in federal law. However, if a state elects to do so it must extend benefits equally to all persons so included, and it must at a minimum extend such discretionary additional coverage to all persons eligible for any of the federally-aided categorical welfare programs in all respects except financial need.

A very significant additional requirement of the original Medicaid law is that federal financial participation in any state's Medicaid program shall continue only so long as

> "the state makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available . . . and . . . liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975 (see below), comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care." - Quoted from Social Security Act, Title XIX, section 1903(e).

An amendment to the above-quoted provision, signed by the President on August 9, 1969, delays the specified date for completion of the prescribed broadening of services to July 1, 1977, and suspends the operation of this provision entirely until July 1, 1971.

Iowa's Eligibility Standards

Section four of the 1967 Medical Assistance Act,

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*An exception to the equal benefits rule permits states to pay, on behalf of indigent residents over 65 years of age, all or part of the "deductible" which Medicare residents must pay toward hospital or nursing home services, and also to pay such persons' premiums for Medicare coverage, without thereby incurring any additional obligation to other Medicaid recipients.

relating to eligibility, states that medical assistance may be provided to or on behalf of any individual or family whose residence is in Iowa,

> "whose income and resources are insufficient to meet the cost of necessary medical care and services, and has no spouse or parent responsible under the law of this state and . . . able to provide him or them with such needed medical care and services."

The determination of ability of a spouse or parent to provide needed care is made by the county board of social welfare. However, medical assistance is not available under the Act to any individual or family:

1. Whose annual cash income after deduction of health care expenses exceeds $1,600 for an individual, or $1,600 for the first adult, $800 for the second adult, and $600 for each additional member of a family.

2. Whose resources after deduction of health care expenses exceed $2,000 for an individual, or $2,000 for the first member, $1,000 for the second member, and $200 for each additional member of a family. In determining the resources available to an applicant for medical assistance, no consideration is given to the value of real property occupied as a residence, household goods and furnishings, personal effects, tools necessary to a trade, occupation, or profession up to a maximum value of $6,000, and the cash surrender value of life insurance up to a maximum of $1,000.

These income and resource limits for Medicaid in effect would enable some persons to receive Medicaid benefits whose incomes or resources make them ineligible for old age assistance, blind assistance, aid to dependent children, or aid to the disabled--or who are in fact eligible, but have not applied, for benefits under one of these categorical welfare programs.

However, section five of the Iowa Medical Assistance Act includes, in subsection one, paragraph d, authority for the Department of Social Services to "establish standards of, or qualifications for, eligibility (for Medicaid benefits) which are more restrictive than those authorized by section four" of the Act, quoted in the preceding paragraph, provided that no such standards or qualifications could operate to make any recipient of one of the four categorical welfare programs ineligible for Medicaid. Pursuant to this authority, the Department initially restricted Medicaid benefits to:

1. Money payment recipients of the categorical welfare

programs and certain dependent relatives of these recipients.

2. Individuals and families eligible for one of the categorical welfare programs in all respects except that:
   - -their income, resources, or both are in excess of maximum eligibility limits.
   - -they do not meet applicable residence requirements.
   - -with respect to certain children under age 21 and otherwise eligible for ADC, they are neither disabled nor regularly attending a high school or receiving vocational or technical training.

In February, 1969, faced with a deficit in the Medical Assistance appropriation for the 1967-1969 biennium, the Department terminated the eligibility of individuals and families under item 2 for further Medicaid benefits.

The cutoff of Medicaid benefits to this group, commonly referred to as the "medical only recipients", was virtually dictated by the lack of funds and the fact that this was the only group to whom benefits could be denied without violating the federal Medicaid law. This circumstance is particularly unfortunate because availability of Medicaid benefits to the medical only recipients was an incentive to many of them to remain off categorical welfare rolls, since Medicaid would bear one of the major items of expense to many low-income families and--in the case of the elderly--does not involve a lien on the property of the recipient as does old age assistance. Conversely, the cutoff of benefits to the medical only recipients tends to create an incentive for them to apply for benefits under a categorical welfare program since this is the only way such persons can now become eligible for Medicaid. Some county welfare directors have stated that they have advised elderly persons with limited incomes, who are ineligible for old age assistance because they have not spent money which they have saved in earlier years, to use such savings for necessary medical expenses and then apply for old age assistance when the savings are depleted.

Also, the cutoff of Medicaid benefits to medical only recipients has in some cases forced such persons to look to county general welfare funds for the cost of necessary medical care, where there is no possibility of establishing eligibility for a categorical welfare program. This appears to have been particularly burdensome to the poor funds of some of the counties, since such expenses were not anticipated when the 1969 budgets were prepared and the cutoff of Medicaid benefits to medical only recipients occurred early in the 1969 county budget year.

The Dimery Case

The limitation of eligibility for Medicaid benefits to

money payment recipients of the categorical welfare programs was continued at the beginning of the 1969-1971 biennium, and remains in effect as this interim report is prepared. However, on October 27, 1969, a special three-judge panel in the United States District Court for the Southern District of Iowa, Central Division, ruled in the case of Porter Dimery, et. al., vs. Department of Social Services, that section five, subsection one, paragraph d, of the 1967 Iowa Medical Assistance Act is an unconstitutional delegation of legislative power to the Department. Since the paragraph cited is the authority on which the Department relied in establishing its original Medicaid eligibility regulations, as well as in effecting the subsequent cutoff of benefits to medical only recipients, the apparent effect of the court's ruling, if upheld on appeal, will be to make all persons and families within the limitations established by section four of the Medical Assistance Act eligible for benefits. This would cause a vast expansion of the Medicaid eligibility roll in Iowa, although the actual effect on costs of the program cannot be determined at this time.

Recommendations

In view of the present unsettled status of a key eligibility provision of the state Medical Assistance Act, the Medicaid Study Committee is not in a position to make a recommendation with respect to any possible revision of eligibility requirements of the Act at this time. It is hoped that a specific recommendation can be made in the not too distant future. However, as a practical matter, it should be realized by all concerned that the Medicaid eligibility standards upon which the Department of Social Services is operating as this interim report is prepared are as restrictive as federal law will presently permit.

Assuming that the federal court decision in the Dimery case stands, it will apparently be necessary to spell out in the Medical Assistance Act more specifically exactly what persons are eligible for Medicaid benefits in Iowa. The immediate legal problem created by the decision presumably could be met by simply writing the standards which the Department of Social Services has in fact been following into law, however this would leave no flexibility for the state to begin broadening coverage of the Medicaid program in the manner which federal law, as presently written, will require after July 1, 1971.

II. - Services Provided

The federal law requires that each state establishing a Medicaid program offer, as a minimum, either the "five basic services" (inpatient hospital care, outpatient hospital care, laboratory and x-ray services, skilled nursing home care, and physicians' services) listed in the Medicaid law, or seven of the total array of fifteen services listed in the law. The most recent contract between the Department of Social Services and the

private carrier for the Medicaid program (see subsequent section of this report entitled "Administration") states that, in Iowa,

> Services for which payment may be made through the Medical Assistance program include care in the home, office, clinic, hospital, or skilled nursing home provided or prescribed by doctors of medicine or osteopathy, chiropractors, podiatrists, dentists, optometrists, opticians, and sickroom supply and medical appliance dealers, licensed to practice in the state of Iowa (if legally required to be licensed) or by members of such professions in other states provided such practitioners are duly licensed in that state. Such services shall include prescribed drugs, medications, sickroom supplies and medical appliances, laboratory, diagnostic and therapeutic services, board, room and services in licensed hospitals and skilled nursing homes and such other services and supplies as may be authorized by practitioners within the scope of their practice and the limitations of the program, if furnished by a vendor included within the scope of the program and shall include such other services and supplies as may be added by the Department.

The various professional and occupational, or "vendor", groups identified in the Medicaid carrier's contract as providing the services and supplies paid for by Medicaid, and the basis upon which payment is made to each group, are as follows:

1. Physicians (medical and osteopathic)	"usual, customary, and reasonable charges unless otherwise directed by federal regulations."
2. Retail pharmacies	usual, customary, and reasonable charge, but not to exceed cost of drug dispensed plus $2.00 professional fee, for drugs; suggested retail price or usual community price, whichever is lower, for sickroom supplies, medical equipment and appliances.
3. Hospitals	identical with basis of payment for part A of Medicare, except deductible and coinsurance provisions do not apply; Medicaid will pay deductible and coinsurance costs for any patient over 65 who is covered by Medicare.
4. Dentists	"usual, customary, and reasonable charges," but not to exceed maximums established by Department of Social Services, and only for those services and supplies listed on a schedule prepared by the Department.

5. Podiatrists	essentially same as for dentists, except federal rules and regulations governing part B of Medicare apply to services covered by Medicare.
6. Optometrists	essentially the same as for dentists, with respect to professional services; payment for eyeglasses and other supplies dispensed is at rate of laboratory cost.
7. Opticians	essentially the same as for optometrists, but Department's schedule of services and supplies for which payment will be approved may not necessarily be the same for optometrists and opticians.
8. Chiropractors	"usual and customary," but not to exceed maximum established by Department (presently $3.50 per office call), only for those procedures listed on a schedule prepared by Department, and not to exceed 4 office calls per month nor 1 x-ray examination per year.
9. Skilled nursing homes	identical with basis of payment for part A of Medicare, except deductible and coinsurance provisions do not apply.
10. Home health agencies	identical with basis of payment for Medicare, except outpatient physical therapy is not covered.
11. Medical equipment, etc.	payment, not to exceed maximums established by Department, is made for all items prescribed by physicians except hearing aids and batteries; prior authorization by county welfare department required for items over $50, and by both county and state Department for items over $150; rental arrangements permissible where economically feasible.
12. Ambulance service	"usual, customary, and reasonable charge," but not to exceed charge to general public for same service, and only for same services as are covered by Medicare.

All claims for health care services rendered or supplies provided to Medicaid recipients are required, by the Medicaid carrier's contract with the Department of Social Services (and ultimately by the federal Medicaid law), to be subjected to procedures collectively designated "utilization review". Appendix II is a flow chart describing these general procedures. The specific procedures involved differ somewhat for the various vendor groups involved in the Medicaid program; for detailed information legislators may wish to consult Schedule L of the Contract for Administration of the Medical Assistance Program, copies of which may be obtained from the Department of Social Services or the Legislative Service Bureau.

Basically, what is initially done is to identify and evaluate all claims representing either a type or amount of service or a charge for the service rendered which is unusual. The guidelines for determining which claims are to receive further evaluation on these bases are called "parameters". Appendix III is a form used by the carrier in reviewing physicians' claims which, in one way or another, exceed applicable parameters.

The fact that a claim exceeds applicable parameters does not necessarily indicate that the claim cannot or should not be paid. The aspect of the claim which exceeds one or another of the applicable parameters may be satisfactorily explained upon review by the carrier's claims examiners or professional consultants (see Appendix II); if not, the claim and relevant information is referred to the Department for further evaluation. If the questions regarding the claim are not resolved by the Department, it is referred to a peer review committee composed of professionals in the same field as the practitioner submitting the claim, and the Committee has the responsibility to make whatever further review is necessary in order to arrive at a recommendation to the Department in the matter.

The peer review committees, most of which are organized on a regional rather than a statewide basis, also play a role in the post-payment evaluation of Medicaid. For example, medical and osteopathic peer review committees reviewed the overall performance with respect to Medicaid patients of all Iowa physicians who received more than $15,000 from Medicaid in the calendar year 1968; dental peer review committees similarly reviewed dentists paid more than $12,000 by Medicaid in 1968. Some Medicaid Study Committee members have questioned the adequacy of reviews with such high threshold levels in terms of total annual payments.

The Department of Social Services has stated that the 1968 post-payment reviews of individual practitioners were a starting point, and has indicated that more inclusive reviews are likely in the future. The Department has praised the attitude of most professional groups in connection with peer review programs, and has asserted that Iowa is one of the leading states in planning and implementing peer review. The Department has also stressed that the overall concept of utilization review is

intended not only to detect instances of abuse through provision of unneeded services or claims for excessive fees, but also to spot instances of failure to provide needed health care treatment and supplies.

In summary, although there are certainly safeguards against abuse built into the Iowa Medicaid program and it is not intended to suggest that these are ineffective, heavy dependence is placed upon the honesty and professional ethics of the practitioners who provide the services and supplies for which Medicaid pays. In evaluating this fact, it must be kept in mind that the professional people who serve upon the various peer review committees generally do so voluntarily. The Department of Social Services bases its procedure on the proposition that the necessary expenditure for a staff of professional health care people who would devote full time to policing Medicaid, taking over some functions of peer review committees, would be very unlikely to reduce the total Medicaid benefits being paid out by an amount great enough to offset the increased administrative costs.

The Committee believes that a desirable policy would be continued reliance upon the existing peer review procedure, but with a systematic attempt to better interpret to the general public, and particularly the Legislature, the role of the peer review committees and, at the same time, to interpret to the peer review committees the concerns of the public regarding Medicaid. A recommendation appears at the conclusion of this section of the Committee's report.

Cost of Medicaid Services

The cost of the Medicaid program to the state treasury is, obviously, one of the General Assembly's paramount concerns regarding the program. It should be clearly understood that a portion of the increased cost is due to a reduction in federal financial participation in the Iowa Medicaid program from approximately 60 to approximately 55 percent, effective July 1, 1969. This reduction was necessary under federal law because Iowa's per capita income had improved in relation to other states in the preceding fiscal year. Therefore, the cost to the state of the Medicaid program during the 1969-1970 fiscal year is relatively heavier than for the previous fiscal year.

As pointed out in section I of the Committee's report, the eligibility standards for Medicaid in Iowa as of the date of the report are as restrictive as federal law will allow. Therefore, if significant restructuring of the program is to be undertaken as a cost control measure, it will apparently have to be done in the areas of services offered or administration.

The federal Medicaid law states in effect that the Secretary of Health, Education, and Welfare shall not approve

a state Medicaid program if he determines that the plan would result in a reduction in the previous level of assistance to categorical welfare recipients. Representative Wilbur Mills, Chairman of the U.S. House Ways and Means Committee, has recently stated that the intent of this provision was to prevent states from reducing cash payments to recipients and diverting the funds thus saved to pay for medical care. However, the Department of Health, Education, and Welfare originally interpreted this provision to mean that a state could not adopt a Medicaid program providing a lesser level of health care benefits than were previously being provided to categorical welfare recipients. Because of this interpretation, Iowa found itself "locked into" providing all categorical welfare recipients--and also, originally, the medical only recipients--the same relatively broad range of services available to the needy aged under the state's Medical Aid to the Aged (Kerr-Mills) program, which preceded Medicaid.

Imposition of a Deductible - Comments to the Medicaid Study Committee by professional persons providing care and services under Medicaid indicate some of them believe that there have been requests on the part of some Medicaid recipients for services not actually needed, or which the recipient would not seek if he or she were required to pay even a small portion of the cost. Some members of the Committee have expressed interest in imposing a "deductible" under Medicaid in Iowa, that is, requiring the recipient to pay a small portion of the cost of some or all services received under Medicare. However, the federal Medicaid law as presently interpreted by the Department of Health, Education, and Welfare, does not permit imposition of a deductible on categorical welfare recipients, who are the only persons presently covered by Medicaid in Iowa.

Reduction of Scope or Extent of Services - It was found possible early in 1969, under then-existing federal law, to take one significant step to limit the services provided under Iowa's Medicaid program, in order to reduce its cost. Since February 1, 1969, Medicaid has paid only for the first ten days of any recipient's stay as an inpatient in a hospital. This presumably has provided an added incentive to discharge Medicaid patients from hospitals as soon after admission as possible, but in cases where it is impossible for Medicaid patients to leave hospitals within ten days after admission, it has forced the patients to look to county general welfare funds or private charity if the hospital is to be paid for more than ten days' care.

The federal Medicaid amendment approved August 9, 1969, specifically permits a state to "reduce the scope or extent of the care and services provided under (Medicare), or to terminate any of such care and services," if in doing so certain conditions are met. These conditions are, essentially, that the state continue to offer at least the "five basic services" listed in the first paragraph of part II of this report, on page 7 (or, alternatively, any seven of the fifteen services listed in the federal

Medicaid law), and that the total expenditure of nonfederal funds by the state for Medicaid not be less after the reduction or termination of services than it was before the reduction or termination. Also, the Governor must certify that the state is "fully complying with" the utilization and cost control provisions of its state Medicaid plan, and that the reduction or termination of services "is not made for the purpose of increasing the standard or other formula for determining payments for" the services which the state does continue to offer under its Medicaid program.

In other words, the state may reduce the scope or extent of its Medicaid benefits, or terminate some services previously offered under the program, in order to try to arrest further increases in the cost of the program, but it may not make a net reduction in the amount of nonfederal money being expended for the program. Also, it may not reduce services, or terminate some of them, in order to raise fees allowed providers of those services and supplies which the state does continue to provide under Medicaid.

As this interim report is prepared, the Department of Social Services is reviewing the options open to Iowa under the August 9 federal Medicaid amendment. It is clear that the state will not be able to reduce the overall cost of the program below present levels, even if this were found acceptable in terms of the effects on the people being served, but it is not clear at this time how the effects of a reduction in scope of services offered would balance against the possibility of preventing or slowing further increases in the cost of the program. The Committee may subsequently wish to make a recommendation on this matter, in the light of further evaluation by the Department of Social Services of the options open to Iowa under the August 9, 1969 amendment, but is not prepared to do so at this time.

Recommendation

As previously noted, the Committee believes there would be value in formalizing lines of communication between peer review committees and legislators and, by extension, the general public. To this end, it is recommended that the Department of Social Services assist the General Assembly in arranging, with the several professional groups whose members provide health care services and supplies to Medicaid recipients, to involve designated legislators as observers and, to the extent feasible, participants in the peer review process. This might be done either at the state level, or by arranging for legislators to meet with regional peer review committees.

III. - Administration

Iowa's Medicaid program is administered by the Department of Social Services' Bureau of Medical Services, of which Dr. Elmer M. Smith is director. Dr. Smith's staff presently includes

two full-time and two part-time professional persons, in addition to himself, and a very small clerical staff.

In discharging its responsibilities under the Medical Assistance Act, the Department is required to "advise and consult at least semiannually with a council composed of" the president of, or other member designated to represent, each of the major professional groups providing services or supplies to Medicaid recipients, as well as a state senator and a state representative of each major political party, a public representative chosen by the Governor, and the Commissioner of Public Health and Dean of the University of Iowa College of Medicine or their respective designees. Appendix IV is a list of the members of this group, officially designated the Medical Assistance Advisory Council.

Employment of Private Carrier

One of the key provisions of the 1967 Medical Assistance Act requires that the Department "to the extent possible, contract with a private organization or organizations . . . (to) handle the processing of and the payment of claims for services rendered under" Medicaid, and that the Department "give due consideration to the advantages of contracting with any organization which may be serving in Iowa as 'intermediary' or 'carrier' under Title XVIII of the federal Social Security Act," (i.e., Medicare). Pursuant to this provision, the Department has from the inception of the program contracted with Hospital Service, Incorporated, of Iowa and Iowa Medical Service (Blue Cross-Blue Shield), which is the Medicare carrier for Iowa, to serve as carrier for the state's Medicaid program.

Blue Cross-Blue Shield has been the only bidder on the Iowa Medicaid carrier contract, which is renewed annually. One other firm at one time indicated an interest in the contract, but did not pursue the matter to the point of entering a bid. The contract for Blue Cross-Blue Shield's services during the July 1, 1969-June 30, 1970 fiscal year was not actually signed until mid-November, 1969, due to prolonged negotiation of certain points. The basic price being paid the carrier by the Department for handling of claims during the current fiscal year is $1.19 per claim, subject to an administrative cost analysis to be completed by September 30, 1970 which could result in an additional billing to the Department of not to exceed 10 percent of the bid price or a refund by the carrier to the Department if the cost analysis shows that administrative costs were less than $1.19 per claim. This compares to a basic contract price of 92¢ per claim, with a somewhat different adjustment procedure, during the preceding fiscal year.

It has been suggested by some parties that the state could, or probably could, act as its own Medicaid carrier at a lower overall cost than is presently being incurred in employment of a private firm to act as carrier. Department of Social Services Administrative Officer James Rowen stated to the Com-

mittee that he would not be willing to say whether the state could or could not effect a net saving by acting as its own Medicaid carrier without a thorough study of the matter. (Minutes of the Medicaid Study Committee meeting of July 30, page 12.)

In hearings held in the course of its September 16-17 meeting, and also on November 5, the Committee inquired of each of the vendor groups involved in the Medicaid program whether members of the group are satisfied with the performance of the carrier. Varying degrees of satisfaction and dissatisfaction were expressed. Several individuals suggested a return to the practice followed under the former Kerr-Mills program of submitting vendors' claims to the county department of social welfare for processing and transmission to the state level.

Presently, vendor claims are submitted directly to the carrier for processing and payment. The time lapse between submission of claims and receipt of payment from the carrier has in the past been a source of great dissatisfaction by vendors. Most vendor group representatives and individual practitioners who attended meetings of the Committee indicated that they consider the carrier's recent performance much more satisfactory, although there continue to be complaints about inability to obtain payment of some long standing claims and certain other aspects of the carrier's operation.

Role of County Welfare Offices

Under the Medicaid program, eligibility determination has remained basically a function of the county departments of social welfare. At present, this function is in effect "automatic" with respect to Medicaid per se, since establishment of eligibility for one of the categorical welfare programs is a prerequisite to eligibility for Medicaid. (County welfare departments formerly also determined eligibility of medical only recipients.) Once eligibility is established, the information is transmitted to the state Department, which is responsible for providing the carrier with continuously updated eligibility information for the entire state coded on magnetic tape. Vendors' claims for supplies and services provided Medicaid recipients are submitted directly to the carrier, not through the county social welfare departments.

Up until the present time, county social welfare departments have been issuing Medicaid eligibility identification cards to recipients at the local level. However, the state Department on December 1, 1969, began issuance of monthly eligibility cards in the form of stubs attached to the benefit checks issued to categorical welfare recipients. It is believed that this procedure will greatly reduce problems which have been experienced with continued use of previously issued cards by individuals who are no longer eligible for Medicaid, and hopefully will make possible a further reduction in the time required for

payment of claims by the carrier.

Officials of the Department of Social Services who have attended Committee meetings have indicated they are not necessarily flatly opposed to having Medicaid claims submitted initially to county social welfare departments, but have pointed out that Medicaid is a much larger program than the former Kerr-Mills program under which health care vendor claims were submitted to the county offices. Some county social welfare directors who appeared before the Committee stated that, as their offices now attempt to help local vendors with problems relating to claims submitted to the carrier and returned for one reason or another, the net additional burden on their staffs might not be too great if Medicaid claims were initially submitted to county social welfare departments. Perhaps more importantly, most of the county directors who appeared seemed to agree that lack of opportunity to review current claims for welfare recipients' health care services and supplies deprives county welfare workers of a valuable source of information about the recipients' needs and overall situations.

Recommendations

1. It is recommended that the Medical Assistance Advisory Council, presently composed of eighteen members, be enlarged to include four public representatives appointed by the Governor, rather than one. This recommendation represents an accommodation between somewhat conflicting desires of Committee members that, on the one hand, public representation on the Council be greater and, on the other hand, that the size of the Council not become unwieldy.

2. The Medicaid Study Committee endorses and urges that the 1970 session pass House File 610, introduced in the 1969 session and presently assigned to the House Social Services Committee. (Similar legislation was under consideration by the Senate Social Services Committee during the 1969 session, but was not formally introduced.) The effect of this bill is to substitute for the present requirement that the Department of Social Services contract with a private carrier to process Medicaid claims, permissive authority for the Department to do so. This change is recommended in part because there has been only one bidder--the present carrier--on the contract to date, and the option for the state to act as its own carrier may introduce an element of competition into the bidding and negotiation on the contract. Also, with the adoption of the bill, the Department would not be placed in an impossible situation if the present carrier should exercise its right to cancel the contract and no other qualified bidder could be found. Finally, the bill gives the Department the option to act as its own carrier, so that it may take advantage of any future opportunity to reduce administrative costs in this manner.

NOTE: It will be necessary for Iowa to enact legislation for the licensing of nursing home administrators before July 1, 1970, in order to comply with the federal Medicaid law. Bills intended to bring the state into compliance with this requirement were before the Sixty-third General Assembly in 1969, but were not passed. The Medicaid Study Committee has not considered in any detail the question of what provisions should be included in such legislation, but wishes to call to the attention of the Legislature the urgency of passing a nursing home administrators licensing measure during the 1970 session.

Summary

The Medicaid Study Committee's assignment has been complex, and in some degree frustrating. The broad scope of the federal Medicaid law, the complexity of this law and the regulations and directives issued pursuant to it, and the relatively rapid implementation of the program by understaffed agencies at both the federal and state level have produced many problems which continue to require much time and effort toward solution. Very shortly before this interim report was completed, a federal study committee released a preliminary report recommending a number of significant steps toward improving administration and effectiveness of the Medicaid program.

At the state level, it has been found that the options for making significant changes in the Medicaid program are limited to a considerable degree by federal regulations. The recommendations which the Committee submits with this interim report do not contemplate basic or far-reaching changes in Iowa's Medicaid program, although as noted in this report the Committee has not yet formulated recommendations on two major points, eligibility and scope of services.

Nevertheless, it is believed that the Committee has already made some important contributions to the improved functioning of the Medicaid program in Iowa. The Committee's meetings with representatives of vendor groups, the Department of Social Services, the private carrier, and county social welfare directors and workers have, we believe, helped to open lines of communication and improve relationships among these groups. The signing in November, 1969, of the new contract between the Department and the carrier, embodying a number of improvements in terms of more specific guidelines for procedure by the carrier in certain areas, is believed to have been a significant step forward in which the Committee played an indirect role. The adoption, effective December 1, 1969, of monthly egilibility cards for Medicaid recipients issued by computer simultaneously with issuance of welfare benefit checks was encouraged, and perhaps accelerated, by the Committee.

In accordance with the terms of House Concurrent Resolution 29, the Medicaid Study Committee intends to continue its work prior to and, if necessary, beyond the convening of the 1970 session of the General Assembly. Every reasonable effort will be made to submit a final report as far in advance of the March 1 deadline as possible.

APPENDIX I

Persons and Representatives of Groups and Firms Appearing before Medicaid Study Committee

The Medicaid Program is administered by the Bureau of Medical Services of the Department of Social Services, and all claims for payment for services or supplies provided recipients are processed by the Department's private contract carrier, Hospital Service, Inc., of Iowa and Iowa Medical Service (Blue Cross-Blue Shield). The Department and the carrier were represented at the Medicaid Study Committee's initial meeting on July 30, 1969, and at all succeeding meetings of the Committee to date, by one or more of the following persons:

Mr. James N. Gillman, Commissioner of Social Services
Mr. James R. Rowen, Acting Deputy Commissioner of Social Services
Dr. Elmer M. Smith, Director, Bureau of Medical Services
Mr. Charles Ballinger, Bureau of Medical Services
Miss Mary E. Staggs, Bureau of Medical Services
Mr. Richard Borchert, Blue Cross-Blue Shield

In addition, the following persons appeared by invitation of the Committee and participated directly in meetings held on the dates indicated. (The list does not include a number of persons who attended but did not participate in one or more meetings of the Committee.)

August 20, 1969

Mr. William Guy, President, Blue Shield
Mr. Paul K. Williams, Director, Clay County Department of Social Welfare

September 16-17, 1969

Dr. Earl Vorland, Iowa Chiropractic Society
Dr. John Miller, Iowa Chiropractic Society
Dr. Larry Lindemann, Iowa Chiropractic Society
Dr. D. E. McAreavy, Iowa Chiropractic Society
Dr. Robert E. Glenn, President, Iowa Dental Association
Dr. Homer Hake, Secretary, Iowa Dental Association
Dr. Richard J. Fuller, (dentist) Des Moines
Dr. John E. Goodrich, Dental Director, Department of Health
Mrs. Marilyn Russell, Chairman, Assembly of Certified Homes Health Agencies of Iowa
Miss Marian Van Fossen, Public Health Nursing Association, Linn County
Mrs. Nancy Buitendorf, Director of Home Health Agency serving Benton, Iowa, Poweshiek, and Tama Counties
Dr. Thomas E. Ward, President, Iowa Optometric Association

Dr. Max Smith, (optometrist) Washington
Dr. Larry DeCook, (optometrist) Newton
Dr. Stewart E. Reed, Iowa Podiatry Society
Dr. William Krigsten, President, Iowa Medical Society
Mr. Eldon Huston, Assistant Executive Vice President, Iowa Medical Society
Dr. L. J. O'Brien, Iowa Medical Society
Dr. Robert B. Stickler, (medical physician) Des Moines
Dr. Gene K. Van Zee, (medical physician) Pella
Dr. Kenneth Carroll, Vice President, Iowa Society of Osteopathic Physicians and Surgeons
Dr. R. G. Hatchitt, (osteopathic physician) Des Moines
Mr. Alden Godwin, President, Iowa Nursing Home Association
Mr. Earl Hawthorne, Park Manor, Inc. (nursing home) Burlington
Mr. Harold Hymans, Garden Court Nursing Homes, Des Moines
Mr. Charles Ingersoll, Iowa Hospital Association
Mr. Louis B. Blair, St. Luke's Methodist Hospital, Cedar Rapids
Dr. Gerhardt Hartman, University of Iowa Hospital, Iowa City

November 5-6, 1969

Mr. Robert G. Gibbs, Executive Secretary, Iowa Pharmaceutical Association
Mr. Gale W. Stapp, President, Iowa Pharmaceutical Association
Mr. Al Van Houweling, Chairman, Committee on Public Assistance, Iowa Pharmaceutical Association
Mr. A. Phillip Coontz, (pharmacist) Waterloo
Mr. William Monroe, (pharmacist) Burlington
Mr. Marion Williams, (pharmacist) Des Moines
Mrs. Cleo Marsolais, Director, Johnson County Department of Social Welfare
Mrs. Gladys J. Harper, Des Moines County Department of Social Welfare
Mrs. Jean Peterson, Director, O'Brien County Department of Social Welfare
Mr. Leland Ahern, Director, Polk County Department of Social Welfare
Miss Marilyn McManus, Supervisor, Medical Assistance Division, Polk County Department of Social Welfare
Mrs. Roberta McClure, former supervisor, Medical Assistance Division, Polk County Department of Social Welfare
Mrs. Doris McQuerry, Food Stamp Division, Polk County Department of Social Welfare
Miss Hattie Hall, Old Age Assistance Division, Polk County Department of Social Welfare
Rev. Milan Thompson, Director, Washington County Department of Social Welfare
Mr. William McDermit, Associate Regional Commissioner, Division of Medical Services, United States Department of Health, Education, and Welfare

Mr. Paul Nixon, Assistant Regional Commissioner, Division of Medical Services, United States Department of Health, Education, and Welfare
Mr. Michael Higgins, United States General Accounting Office
Mr. Maurice R. Griffin, Regional Claim Manager, Mutual of Omaha Insurance Company
Mr. Jack Dillon, Claims Manager, Chet Elson and Associates of Des Moines, Inc., general agent for Mutual of Omaha Insurance Company
Mr. Kenneth Barrows, Second Vice President, Claims Department, The Bankers Life Company
Mr. Jerry Eischeid, Supervisor, Regional Claims Services, The Bankers Life Company

Claims Review Subcommittee - November 17, 1969

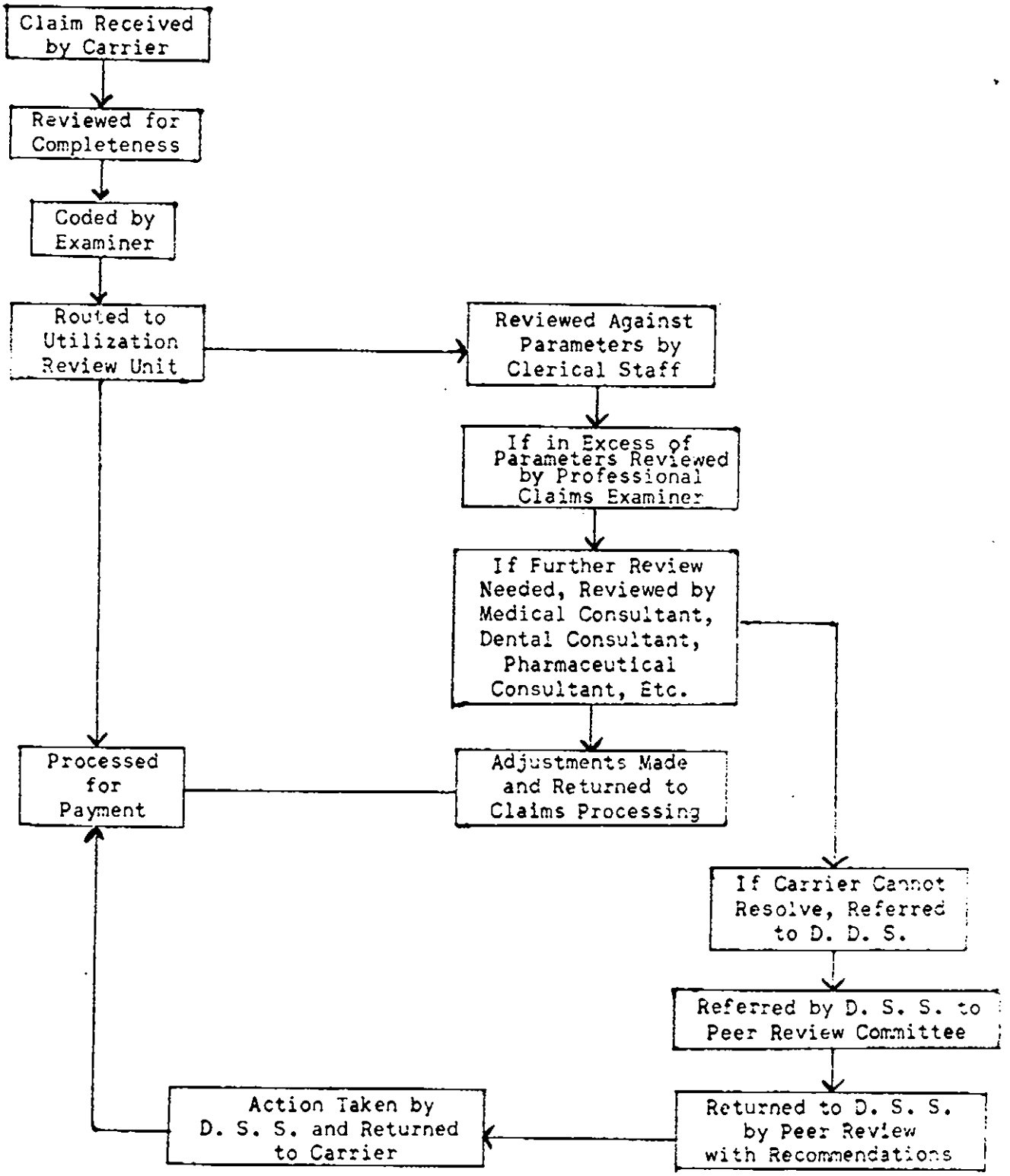
Mr. Cleo Green, Director, Data Processing Division, Department of Social Services
Mr. Bill Waddams, Blue Cross-Blue Shield

APPENDIX II

State of Iowa
Department of Social Services

Title XIX - Medical Assistance

UTILIZATION REVIEW PROCEDURE



TITLE XIX
QUALITY ASSURANCE ROUTING FORM

TO: *QUALITY ASSURANCE DEPARTMENT* FROM: _____ DATE: _____
LIBERTY BUILDING – 6th FLOOR *Q.A. REC'D DATE* _____ *Q.A. DISPO. DATE* _____

REASON FOR REFERRAL:

- ☐ 1 OUTPATIENT DIAGNOSTIC X-RAY AND/OR LABORATORY CLAIMS FOR FIVE OR MORE SERVICES OR FOR MORE THAN $35 TOTAL CHARGE.
- ☐ 2 CLAIMS FOR RECIPIENT UNDER 65 FOR PERIODS OF HOSPITALIZATION THAT EXCEED 15 CONSECUTIVE DAYS OR 30 CONSECUTIVE DAYS FOR C.V.A.'s, CORONARY DISEASES, HIP FRACTURES AND PSYCHIATRIC CARE RENDERED BY A PSYCHIATRIST.
- ☐ 3. CLAIMS FOR RECIPIENT OVER 65 THAT SHOW THIRTY OR MORE HOSPITAL VISITS WITH THE EXCEPTION OF HIP FRACTURES, CORONARY DISEASES, STROKES AND PSYCHIATRIC CARE WHEN RENDERED BY A PSYCHIATRIS
- ☐ 4. CLAIMS IN EXCESS OF 2 FOR SERIES OF HOSPITALIZATION WITH THE EXCEPTION OF OBSTETRICAL CARE, T & A's AND ACCIDENTAL INJURIES.
- ☐ 5. CLAIMS THAT INDICATE TWO OR MORE PHYSICIANS ARE TREATING THE SAME DIAGNOSIS WITH NO EVIDENCE THAT SUPPLEMENTAL SKILLS ARE REQUIRED.
- ☐ 6. GANG VISITS (OFFICE & HOME) FOR 2 OR MORE MEMBERS OF A FAMILY ON THE VISIT.
- ☐ 7. CLAIMS FOR INJECTIONS IN EXCESS OF FIVE PER MONTH.
- ☐ 8. CLAIMS FOR NURSING HOME VISITS IN EXCESS OF 2 PER MONTH OR E.C.F. IN EXCESS OF 5 PER MONTH.
- ☐ 9. CLAIMS FOR OFFICE, CLINIC, OR HOME VISITS IN EXCESS OF 5 PER MONTH.
- ☐ 10. DOCTOR KICK-OUT (SEE LIST).
- ☐ 11. OTHER _____

BREAKDOWN OF CHARGES:

DOCTOR: ☐ M.D. ☐ D.O. ☐ G.P. ☐ SPECIALIST

DATES OF SERVICE		PL. of Trt.	Day Vst.	SERVICES PERFORMED	DIAGNOSIS	CHARGE

BREAKDOWN OF CHARGES:

DOCTOR: ☐ M.D. ☐ D.O. ☐ G.P ☐ SPECIALIST

DATES OF SERVICE		PL. of Trt.	Day Vst.	SERVICES PERFORMED	DIAGNOSIS	CHARGE

REMARKS: _____

QUALITY ASSURANCE DISPOSITION

- ☐ PAY ENTIRE _____
- ☐ DISALLOW _____
- ☐ PARTIAL DISALLOW $ _____
- ☐ ADDITIONAL INFORMATION NEEDED – REQUEST _____

ADJUDICATOR.

DATE	BY

QA 8 9/69

APPENDIX IV

Members of Medical Assistance Advisory Council

Member	(representing)	Organization
L. J. O'Brien, M.D.		Iowa Medical Society
Ronald K. Woods, D.O.		Iowa Society of Osteopathic Physicians and Surgeons
A. G. Kegler, D.D.S.		Iowa State Dental Society
Nellie Osterlund, R.N.		Iowa State Nurses Association
Robert G. Gibbs		Iowa Pharmaceutical Association
Stewart E. Reed, D.S.C.		Iowa Podiatry Society
Richard C. Schiller, O.D.		Iowa Optometric Association
Darrell G. Hartline		Iowa Hospital Association
Mrs. Alixe P. Nuzum		Iowa Osteopathic Hospitals
Alden R. Godwin		Iowa Nursing Home Association
E. C. Vorland, D.C.		Iowa State Board of Chiropractic Examiners
Representative A. June Franklin		State Representative (Democratic)
Representative Joan Lipsky		State Representative (Republican)
Senator Ernest Kosek		State Senator (Republican)
Senator William Palmer		State Senator (Democratic)
James F. Speers*		Commissioner of Health
William O. Rieke		College of Medicine, University of Iowa
Sue M. Reed		Public Member

*Dr. Speers has resigned as Commissioner of Health effective December 31, 1969.