Medical Assistance Crisis Intervention Team

Final Report

Prepared for the Iowa General Assembly and Governor Tom Vilsack

December 1, 2004

Statement By Chairperson David Skorton

I am pleased to submit this report to the Iowa General Assembly and to the Governor on behalf of the Medical Assistance Crisis Intervention Team (MACIT). All team members join me in thanking the Legislature and Governor for the opportunity of engaging with the public, with other experts in our state, and with each other in this area of critical need in our state.

Our hearings were well attended and permitted the public to share important insights, experiences, and opinions regarding the Medicaid program and other aspects of health care delivery in our state. We believe that the Medicaid program is an essential safety net for our least fortunate neighbors and that, through a judicious combination of organization of health care delivery, expenditure control, and targeted revenue enhancement, we believe the program must be sustained over the long run as a high priority to protect the state's citizens. For that reason, we recommend against cuts in services, eligibles or provider reimbursement.

Perhaps most important for the long term among the recommendations of the team is the establishment of a standing commission on health care to continue dialogue regarding all elements involved in the Iowa health care delivery environment, not just Medicaid.

We look forward to your reaction to this report, and stand ready to answer any questions that you may have regarding our process or outcomes.

Acknowledgment

On behalf of the MACIT, I wish to acknowledge the very effective efforts of Dr. Stacey Cyphert and Mark Braun in the work of the MACIT. Particular thanks goes to Dr. Cyphert for his assistance in documenting MACIT activities and drafting the final report and to Mr. Braun for broad advice on legislative issues.

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Executive Summary

The Medical Assistance Crisis Intervention Team (MACIT) was created during the second regular session of the 80th Iowa General Assembly to provide a projection of the medical assistance program costs through June 30, 2008, hold at least four public meetings in geographically balanced venues across the state to gather public input on this important program, and to submit a report to the Iowa General Assembly by December 1, 2004. The MACIT was also permitted, but not required, to make additional recommendations.

A ten-member Team was led by University of Iowa President David Skorton. It held public meetings in Des Moines, Dubuque, Mason City, Ottumwa, Red Oak, and Sioux City between July and November 2004. These meetings were well attended and ranged in size from approximately 50 to 150 people. Subject matter experts were invited to present at the meetings to inform Team members and the public about specific issues. Over two hours of each Team meeting, however, were devoted specifically to public comment. In addition, members of the public were provided with written and electronic options for communicating with the MACIT throughout the course of its existence.

Among the major public comment themes expressed were: without Medicaid many people will not have access to health care; health care is a major employer (economic engine) throughout Iowa, especially in rural areas, and cuts in Medicaid reimbursement have serious implications for financial viability and may lead to provider shortages and/or decreased access to care; care must be taken that changes in one area do not simply shift costs or lead to even greater expenses in another area; incentives to encourage people to purchase long-term care insurance should be explored; need to find sources of new revenue to support Medicaid rather than cutting the program; and, there is a need for changes at the federal level with respect to waivers to permit improvements in efficiency and cost-effectiveness.

The estimated future General Fund costs of Iowa Medicaid through FY 08 are depicted in the table below. This is not the entire cost of Iowa's Medicaid program, nor is it the entire amount of state and local dollars that must be spent to draw down the federal match. Rather, this is the best estimate of the General Fund dollars that must be committed to Iowa's Medicaid program absent new sources of revenue. Version 1 assumes that intergovernmental transfers (IGTs) continue to be available throughout the projection period. Version 2 assumes that IGTs will not continue to be available. Each version is presented with two trends. Trend 1 assumes current policies continue and transfers from the Senior Living Trust Fund continue through FY 06. Trend 2 assumes the unit cost trend rate is 2.5% higher for all categories of service and Senior Living Trust Fund transfers stop after FY 05.

Estimated General Fund Costs of Iowa Medicaid

Year	Version 1		Version 2	
	Trend 1	Trend 2	Trend 1	Trend 2
FY 05	$431 M	$431 M	$448 M	$448 M
FY 06	$476 M	$668 M	$514 M	$705 M
FY 07	$630 M	$695 M	$690 M	$755 M
FY 08	$653 M	$722 M	$737 M	$806 M
% Increase FY 05-08	51.5%	67.5%	64.5%	79.9%

As illustrated by the data in this table, approximately a 50 percent to 80 percent increase in General Fund dollars devoted to Iowa's Medicaid program will need to occur between FY 05 and FY 08 absent other sources of revenue or massive cuts in the program. This rate of increase is likely to represent a significant challenge for the State.

The MACIT arrived at five major findings during the course of its work. These include:

1) Iowa's families, who rely on Medicaid as a means of receiving their health care, will suffer real hardships if they are considered no longer eligible, or cannot receive the services from qualified providers because of potential cuts to eligibility, services or provider reimbursement rates.

2) Iowa's Medicaid program and the associated expenditures of 13% of the state General Fund are a lower percentage of our state budget than other states in our region and are well below the national average, even when adjusted for the use of our one-time and time-limited funds. Iowa's Medicaid program has been conservative despite growing costs.

3) Iowa's Medicaid program is efficient and of high quality. According to the Centers for Medicare & Medicaid Services (CMS) and reported by the Journal of the American Medical Association in January, 2003, Iowa ranks 6th best in the quality of care offered compared to other states.

4) Iowa's Medicaid providers are operating at FY 2000 payment levels and rising costs and increased administrative burdens add additional stress to the system. Cuts to reimbursement rates would significantly impact an already fragile health care system and providers will question their ability to remain in the Medicaid program, impacting access to needed health care services available to Iowa Medicaid patients in both rural and urban areas.

5) The Iowa Medicaid program cannot sustain a cut of $130M without devastating the program – additional sources of revenue need to be identified.

The MACIT, as it was permitted to do, opted to develop several recommendations regarding Iowa's medical assistance program. Perhaps the most significant

recommendations are that no cuts should be made to eligibles, services, or reimbursement to providers. Additional recommendations are encompassed within seven categories, including: overarching issues; expense management; state / federal partnerships; prevention / education; case management / care management; practice / organizational issues; and, revenue enhancements. Rather than issue majority and minority reports, the MACIT attempted to identify whether or not it was unanimous on the recommendations made.

The overarching issues recommendations include: support for the goal of universal health coverage be communicated to Iowa's federal delegation for enactment on a national level; looking at what the state does well and encouraging the Department of Human Services to continue to be flexible and permit innovation in cost-effectively meeting the needs of Iowa's Medicaid population; increasing scrutiny for fraud and abuse; creating a standing commission on health care with broad representation; pursuing legislation at the federal level regarding select aspects of the National Conference of State Legislature's proposal to increase flexibility, increase financial resources, and decrease state risk; and, medical liability reform. All except the universal health coverage recommendation in this category enjoyed the unanimous support of the MACIT.

The expense management recommendations include: implementation of a preferred drug list; provide incentives to purchase long-term care insurance; and reduce regulatory burdens. Disagreement existed within the MACIT regarding whether or not to endorse expanding Medicaid managed care in Iowa.

With respect to state / federal partnerships, the consensus of the MACIT was, even with its recognition of the innovations in the proposal, that absent additional information to questions raised, as well as Iowa's congressional delegation's endorsement of the implications for Iowa, that it could not endorse the Iowa Department of Human Services proposal to CMS regarding intergovernmental transfers and related issues at the current time. The MACIT did endorse opposition to block granting of Medicaid or other entitlement caps that would serve to shift costs to states and reduce state's capacities to serve those in need.

The MACIT's prevention / education recommendation involved endorsing the greater involvement of patients in their own care.

The case management / care management recommendations included: support for continuation and expansion of the Iowa Drug Utilization Review Commission activities; support for collaboration between physicians and pharmacists to assure quality care for their common patients; pharmaceutical purchasing cooperatives; and utilizing the Canadian strategy of using the purchasing power of the government, in our case CMS, to negotiate reasonable pharmaceutical prices from manufacturers.

With respect to practice / organizational issues, the MACIT expressed support for an informed debate supported by facts and scientific evidence on the merits of scope of

practice changes but did not offer any specific proposals. Additionally, the MACIT advances without comment an expansion of the role and numbers of Community Health Centers, a requirement for universal pre-admission assessment, the creation of a statewide small business health and prescription drug purchasing pool, and development of a lay health worker program.

Finally, the MACIT developed several recommendations pertaining to revenue enhancements. These included: seeking temporary federal support to assist states with a transition to more stable funding such as was proposed in S. 2671, the State Fiscal Relief Act of 2004; increasing the tax on tobacco to at least $1 per pack and earmarking the additional revenue for the Medical Assistance Program; taxing advertising that promotes unhealthy consequences and designating the proceeds to the medical assistance program; increasing the tax on alcohol and designating the proceeds to the medical assistance program; and, supporting the efforts of the long-term care profession to establish a quality assurance fee proposal with revenue to be distributed as previously directed in HF 619.