Bill History for HF 841

By Gipp and Murphy.

A bill for an act relating to health care reform, including provisions relating to the medical assistance program, providing appropriations, providing effective dates, and providing for retroactive applicability. Various effective dates and contingency dates. See section 66.

April 5, 2005	Introduced, referred to Human Resources. H.J. 1112.
April 6, 2005	Subcommittee, Carroll, Foege, Heaton, Smith and Upmeyer. H.J. 1158.
April 13, 2005	Committee report, recommending amendment and passage. H.J. 1222.
April 13, 2005	Pursuant to Rule 31.7. H.J. 1222.
April 13, 2005	Referred to Ways & Means. H.J. 1222.
April 13, 2005	Committee amendment H-1362 filed. H.J. 1224.
April 14, 2005	Committee report, recommending amendment and passage. H.J. 1253.
April 14, 2005	Pursuant to Rule 31.7. H.J. 1253.
April 14, 2005	Referred to Appropriations. H.J. 1253.
April 14, 2005	Committee amendment H-1375 filed. H.J. 1254.
April 15, 2005	Committee report, recommending passage. H.J. 1259.
April 19, 2005	Amendments H-1417, H-1426, H-1427 filed. H.J. 1334.
April 20, 2005	Committee amendment H-1362 withdrawn. H.J. 1350.
April 20, 2005	Committee amendment H-1375 withdrawn. H.J. 1350.
April 20, 2005	Amendment H-1433 to H-1417 filed. H.J. 1387.
April 20, 2005	Amendment H-1433 to H-1417 adopted. H.J. 1388.
April 20, 2005	Amendment H-1427 to H-1417 adopted. H.J. 1389.
April 20, 2005	Amendment H-1449 to H-1417 filed. H.J. 1389.
April 20, 2005	Amendment H-1449 to H-1417 adopted. H.J. 1391.
April 20, 2005	Amendment H-1426 to H-1417 adopted. H.J. 1391.
April 20, 2005	Amendment H-1448 to H-1417 filed. H.J. 1391.
April 20, 2005	Amendment H-1448 to H-1417 lost. H.J. 1392.
April 20, 2005	Amendment H-1454 to H-1417 filed. H.J. 1392.
April 20, 2005	Amendment H-1454A to H-1417 adopted. H.J. 1395.
April 20, 2005	Amendment H-1452 to H-1417 filed, withdrawn. H.J. 1395.
April 20, 2005	Amendment H-1455 to H-1417 filed. H.J. 1395.

April 20, 2005	Amendment H-1455 to H-1417 adopted. H.J. 1396.
April 20, 2005	Amendment H-1454B to H-1417 withdrawn. H.J. 1396.
April 20, 2005	Amendment H-1443 to H-1417 filed, lost. H.J. 1397.
April 20, 2005	Amendment H-1417 as amended, adopted. H.J. 1397.
April 20, 2005	Passed House, ayes 100, nays none. H.J. 1397.
April 20, 2005	Immediate message. H.J. 1398.
April 21, 2005	Message from House. S.J. 982.
April 21, 2005	Read first time, referred to Appropriations. S.J. 983.
April 26, 2005	Subcommittee, Hatch, Tinsman, Angelo, Dvorsky, Ragan, and Seymour. S.J. 1023.
May 3, 2005	Committee report, without recommendation. S.J. 1115.
May 4, 2005	Amendment S-3243 filed, adopted. S.J. 1127.
May 4, 2005	Amendment S-3254 filed, adopted. S.J. 1127.
May 4, 2005	Amendment S-3247 filed, lost. S.J. 1127.
May 4, 2005	Amendment S-3246 filed, withdrawn. S.J. 1128.
May 4, 2005	Passed Senate, ayes 41, nays 9. S.J. 1128.
May 4, 2005	Motion filed to reconsider vote on bill. S.J. 1137.
May 4, 2005	Motion filed to reconsider vote on bill. S.J. 1137.
May 6, 2005	Motions to reconsider vote withdrawn. S.J. 1169.
May 6, 2005	Immediate message. S.J. 1170.
May 9, 2005	Message from Senate. H.J. 1746.
May 9, 2005	Senate amendment H-1636. H.J. 1748.
May 9, 2005	House concurred H-1636. H.J. 1752.
May 9, 2005	Passed House, ayes 93, nays 1. H.J. 1752.
May 11, 2005	Message from House. S.J. 1183.
May 12, 2005	Reported correctly enrolled, signed by Speaker and President. H.J. 1931.
May 12, 2005	Sent to Governor. H.J. 1931.
May 12, 2005	Signed by Governor. H.J. 1946.

Subcommittee meetings in House:

April 5, 2005---Presentation in House Chamber on Iowa Medicaid Reform at 9am with Governor Vilsack, Director Concannon, Medicaid Director Gessow, and Representative Carroll

April 6, 2005-- Subcommittee in Room 103 at 4pm

April 7, 2005--Subcommittee following conclusion of Human Resources Committee at 10am.

April 11, 2005--Subcommittee

April 12, 2005. Presentation in the Senate Chamber on HF 841.

Subcommittee meetings in Senate:

April 28, 2005--Subcommittee in room 22 at 11:30am

April 29, 2005--Subcommittee in room 22 at 10:30 am

This document was prepared by staff from the Legislative Services Agency and the Department of Human Services to provide additional information about the Medicaid Reform Proposal.

A Plan for Iowa Medicaid Reform

Goals, Strategies and Options

1. Preserve the Medicaid system we have in place today (eligibility, services, and rates). Fill in the FY 2006 $65 million General Fund shortfall due to loss of Intergovernmental Transfers (IGTs) by:

- *Shifting State costs to a federally matched program by expanding Medicaid to 200% of the Federal Poverty Level, on a limited basis.*
- *Maximizing Iowa's federal Disproportionate Share Hospitals (DSH) and Indirect Medical Education (IME) payments at the Mental Health Institutions, University of Iowa Hospital, and Broadlawns Hospital.*
- *Implementing Medicaid Reform principals in the Medicaid Expansion Program.*

2. Preserve our safety net providers through the Medicaid Expansion and DSH/IME Funding:

Tier 1: Hold harmless Broadlawns, UIHC and MHI for loss of appropriated funds.

Tier 2. Free clinics, FQHC and RHC.

Tier 3. Other health care providers.

A. Initiative for Optimal Wellness Assurance (IOWA) Program

- *Beginning July 1, 2005, if federal matching funds are received, expand the Medicaid Program to up to 200% of the Federal Poverty Level, to include:*
  - *Adults age 19 – 64.*
  - *Income not to exceed 200% FPL.*
  - *Benefits limited to Inpatient, Outpatient and Physician services.*
  - *Providers limited to the University of Iowa Hospitals and Clinics, Broadlawns Hospital, and the State Mental Health Institutes.*
  - *Enrollment may be capped, closed or reduced if funds are not available.*
  - *Local funds may be used as State Match.*

B. More effectively utilize existing funding

- *The Hospital Trust Fund would be the mechanism for funding the IOWA Program.*
- *The revenue sources to the Fund are General Fund appropriations, transfers from local governments, federal Medicaid matching funds, Disproportionate Share Hospitals matching funds and Indirect Medical Education matching funds.*
- *The estimated total expenditures (state and federal funds) for the Program are $91 million for the following appropriations:*
  - *$27 million to the University of Iowa.*
  - *$34 million to Broadlawns Hospital.*
  - *$30 million to the Mental Health Institutes.*
  - *The State match is $33 million, federal match is $58 million, for a total of $91 million.*

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3/24/05

- *These amounts are equal to the amount they currently receive in 100% state or county funds.*
- *The appropriations will be paid on a prospective basis in 1/12th installments, with a cost settlement at the end of each fiscal year.*

- *The Department of Human Services will determine in December of each year the amount expended for the IOWA Program at each institution and the number served, and estimated the amount for the remainder of the fiscal year. This represents the IOWA Program expenditures to the three entities.*
- *The DHS will determine, at the same time, the difference between the IOWA Program expenditures and the appropriation amount to each institution. The difference will be made up through Disproportionate Share Hospitals and Indirect Medical Education payments.*
- *The institutions will be held harmless. They will receive the same amount of funding as currently. However, the funding will now be 1/3 state funds, 2/3 federal funds, and the payments will be made from the Hospital Trust Fund from a combination of IOWA Program (Medicaid) funds, Disproportionate Share Hospitals and Indirect Medical Education Funds.*
- *Broadlawns semi-annual collection of property tax funds (approximately $34 million) will be paid directly to the Fund and used as state match for the Program.*

C. Additional requirements to implement the Program.

- *Medicaid payments shall be based on actual Medicaid costs.*
- *DHS shall develop a Hospital Disproportionate Share Program:*
  - *The Program shall be designed to make payments to the University of Iowa Hospital, Broadlawns Hospital, and the Mental Health Institutions.*
  - *The Program shall maximize federal payments to the state.*
  - *Shall be operated through the Hospital Trust Fund.*
  - *Shall make up any difference between the Hospital Trust Fund appropriation and the amount of reimbursement received through the IOWA Program.*

3. No change in distribution of real, non-IGT DSH at current levels. New rules for balance of DSH.

4. Medicaid Reform – Service, Coverage, Rates, Quality and Personal Responsibility

A. Expand Access to Care

- ☐ *By July 1, 2005, begin to expand Medicaid coverage for the uninsured and underinsured Iowans at or below 200% of FPL (expansion population) for certain inpatient and outpatient hospital services (expansion coverage) provided through a limited provider network (expansion network), the IOWA Program.*

- ☐ *If practical, require all expansion program members to enroll in the Primary Care Case Management program and/or to utilize a 24/7 nursing hotline prior to accessing emergency room care, and other incentives (such as financial incentives) to encourage preventative rather than emergency care.*

- ☐ *By July 1, 2006, establish a pharmacy assistance hotline for the expansion population and other interested Iowans which matches free prescription drug programs provided to the public by the pharmaceutical industry. (House File 821)*

- *Implement the Family Planning Waiver (already enacted in law and awaiting federal approval).*

- *Contract with Department of Insurance to track annually the number of uninsured and underinsured Iowans, the cost of private market insurance coverage and other barriers to access to private insurance for all Iowans.*

B. Improve the health of Iowa Medicaid members

- *Enrollees will be required to utilize a "medical home" including, but not limited to a nurse hotline, primary care case manager, and other incentives to encourage or require use of primary care over emergency care.*

- *Require that each new admit to the expansion program get a medical evaluation and personal health care plan. Track self assessment of member compliance with plan. Evaluation and plans may be provided by any physician, licensed nurse practitioner, or qualified physician's assistant.*

- *Design and successfully implement a strategy to reduce smoking among Medicaid covered children to <1% and among adults to < 10% by July 1, 2007. Evaluate performance annually.*

- *Design and implement a funded "dental home" program for every child age 12 and younger in the Medicaid program by July 1, 2008. At a minimum each child with a home shall receive the dental screenings and preventive care identified in the EPSDT oral health standards.*

C. Require and promote personal financial participation in the cost of care for all persons covered by the Iowa Program/Medicaid expansion through the waiver.

- *The expansion population shall be required to pay a monthly premium not to exceed 1/12th of 5% of their annual family income- and must pay monthly premiums for at least four months, without regard to length of enrollment. No individual shall be required to pay any premium if the Department determines that the total cost of collection exceeds 95% of the premium collected. The Department shall select an Administrative Services Organization (ASO) to bill, collect, remit and report, all insurance premiums. Payment may be at grocery stores and pharmacies throughout the State. Timely payment of premiums, including any arrearages from prior enrollment, is a condition of receiving any Medicaid services. The expansion population shall also be required to pay the same co-payments required of other adults in the Medicaid program.*

- *Develop a plan to test the utility of health care accounts beginning July 1, 2006. Health care accounts are a form of Medicaid benefit available only to adults who have been enrolled in the Medicaid program for at least twelve calendar months. The member voluntarily agrees to exchange for one year the benefit package for which he or she would be entitled for a credit of up to $1,000 towards any Medicaid covered service. The balance in the account at the end of the year, if any, may be withdrawn in cash by the member.*

D. Promote and facilitate rebalancing the long term care system for both the physically and mentally challenged – serve more people with the same dollars.

- *Raise the level of care for admission to nursing homes except where it is determined to be medically necessary, unless no appropriate waiver services are actually available at that time in their community.*
  - Nursing Facility level services in Medicaid shall only be available under the following criteria:
    - Requires physical assistance of one or more persons on a daily basis for three or more activities of daily living.
    - Requires a safe, secure environment for the chronically confused or mentally ill.
    - Has a dependency requiring residence in a medical institution for more than one year.
  - Home and Community Based Services Waiver shall only be available under the following criteria:
    - Requires hands-on assistance on a daily basis with one to three activities of daily living.
    - Requires a safe, secure environment for the chronically confused or mentally ill.
- *Appropriately amend nursing home regulations to expand opportunities for the nursing home profession to utilize its facilities, personnel and infrastructure more efficiently for community-based long term services.*
- *Provide parents with children who require PMIC level care to receive the care they require outside of an institution with the assistance of waiver services once the appropriate federal conditions are satisfied.*

E. Promote and facilitate rebalancing the long term care system for the mentally retarded and developmentally disabled.

- *Develop and implement by January 1, 2007 a case-mixed adjusted reimbursement system for both institutional and community based services for the developmentally disabled.*
- *Raise the level of care for admission to an ICF/MR, except where it is determined to be medically necessary, unless no appropriate waiver services are actually available at that time in their community.*
- *Request that the University of Iowa Medical School and Dental Schools to explore whether the physical health and oral health needs of this Medicaid population are being regularly and fully addressed and identify an barriers to care. Report by January 1, 2007.*

F. Recognize/reward provider performance and member performance.

- *Design and implement by July 1, 2006 a funded Provider Incentive Payment (PIP) program, after evaluating models from both the public and private sector.*
- *Reduce the premium and co-pay for expansion members who do not smoke or who stop smoking by 50% for all services and who demonstrate compliance with the individual health plan developed when the member entered the program.*

G. Facilitate integration of Medicaid with the private health insurance market.

- *Design a program to provide premium and/or co-pay and deductible support as an alternative benefit for individuals in the expansion program who have access to, but financially cannot afford to participate in employer health insurance plans. Report on the program design to the legislature by March 15, 2006.*

- *Require all expansion members to be screened for participation in the Iowa HIPP program (Health Insurance Payment Program).*

- *DHS to hire a consulting firm to provide a cost/quality-benefit analysis to DHS by March 1, 2006 on expanding the use of capitated managed care to each Medicaid population.*

H. Use more Medicare/private insurer/private provider – clinically appropriate – health care utilization management strategies.

- *Establish a committee of clinicians under the chair of the Iowa Medical Education (IME) Medical Director to recommend to the DHS clinically appropriate health care utilization management and coverage decisions for adoption by the Iowa Medicaid program. (Exclusive of pharmacy which is already covered by the Drug Utilization Review and the Preferred Drug List Pharmaceutical and Therapeutics Committee).*

I. Adopt business-like, market-based, clinically sensitive health care pricing/purchasing standards for the Medicaid system.

- *Establish an advisory commission by January 1, 2005 on service pricing which will receive information on third party payor rates in Iowa and, where appropriate, usual and customary charges of providers. Based on a business model and the federal pricing standard (sufficient to provide access to care to the same extent available to the general population) the Commission shall regularly review and make recommendations for pricing changes. Appropriate protections for confidential business information. At least one member of the commission shall be a health care economist.*

J. Expand access to electronic medical recordkeeping (EMR) systems for Medicaid providers and their patients to improve the quality of care and reduce avoidable medical errors.

- *Develop a plan ready to <u>begin</u> implementation on July 1, 2006 to expand electronic medical recordkeeping by Medicaid providers serving those members whose quality of care will be significantly enhanced by the availability of EMRs.*

5. Medicaid Reform – Program and Financial Accountability

A. Retain an independent Certified Public Account to provide an opinion annually to the Governor that the Iowa Medicaid system meets each of the following three financial conditions, beginning with SFY 2006.

- *No new provider taxes as those are defined in CMS regulations.*

- *Public hospitals and nursing facilities are paid no more than their actual costs of care for the Medicaid and DSH patients they treat based on Medicare principles of accounting/cost reporting.*

- *No recycling of federal Title IX dollars as defined by CMS.*

B. Establish a Joint Legislative Committee on Medicaid with responsibility for:

- *Quarterly Medicaid Cost Projections.*

- *Reviewing quarterly reports on all Medicaid Reform Initiatives, including those in operation and those in the DDI (design, development and implementation phase). Recommend a SFY 2007 and SFY 2008 reform program to the legislature and the Governor.*

- *Reviewing quarterly reports on the success of the Iowa Medicaid Enterprise as measured against the current contractual performance measures for each of the IME partners.*

- *Assuring that the Medicaid expansion program is managed at all times within the appropriated amount. The Committee must assume that no supplemental appropriation will be available to cover any overspending for services for the expansion population (those who are covered solely as a result of the waiver).*

C. No less than 50% of the Medicaid Assistance Advisory Council shall be Iowa Medicaid members. A quorum of the Council must include no less than 50% of the Iowa Medicaid members serving on the Council.

This document was prepared by staff from the Legislative Services Agency and the Department of Human Services to provide additional information about the Medicaid Reform Proposal.

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A Plan for Iowa Medicaid Reform

Frequently Asked Questions

Last Updated 3/30/05

Financing

Q 1: How can we expand Medicaid without an increase in State expenditures?

A: Iowa currently expends approximately $100 million in State and County funds for health care services to the uninsured through the University of Iowa Hospitals and Clinics (UIHC) State Papers/Indigent Care Program, Broadlawns Hospital's property tax levy, and State General Fund appropriations to the Mental Health Institutions.

Under the proposal, Medicaid would be expanded in a very specific and limited way to include people currently covered by these programs. The Medicaid program is funded 63.55% by the federal government. As a result, it only takes $35 million in State funds to match roughly $65 million in federal funds, for a total of $100 million in expenditures. This provides $65 million in savings to the State General Fund.

Q 2: Does this proposal result in an increase in State General Fund expenditures or Federal expenditures?

A: No. As outlined above, the intent is to achieve a General Fund savings that will essentially offset the loss of revenue to the state due to the 'inappropriate' use of Intergovernmental Transfers (IGTs). This prevents disruption of services, coverage and eligibility of existing recipients of Iowa Medicaid.

Q 3: Will the entire amount of the appropriations to the entities ($27 million to University of Iowa, $34 million to Broadlawns, and $30 million to the Mental Health Institutes) be used for the Medicaid expansion State match?

A: No. The Medicaid expansion will not cover all who are currently served by these programs. The intent of the proposal is for Disproportionate Share Hospitals (DSH) and Indirect Medical Education (IME) funding (which are also federally matched) to help cover what is not covered by the Medicaid expansion. For example, if Medicaid expansion payments to the University of Iowa are $17 million (State and federal funds), then $10 million could be paid from a combination of DSH and IME funding (State and federal funds). All three of these funding sources will flow through the Hospital Trust Fund. The amounts from each source will be determined by the Department of Human Services (DHS), with oversight from the joint legislative Medicaid committee.

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Q 4: What is the role of Disproportionate Share Hospitals funding?

A: Currently, Iowa has two DSH programs. The first program, approximately $6.8 million total state and federal funds, is paid to hospitals throughout the State (including the UIHC) to address uncompensated care. The second program is an 'inappropriate' IGT through the UIHC, which results in revenue to the Medicaid Program of $18 million federal funds.

The IGT program is being eliminated by the federal government, so the DSH funds will no longer be used for the IGT. Federal DSH dollars are granted to the States through a maximum allotment; therefore, the DSH funding is still available to Iowa for appropriate uses. Under the Iowa Medicaid Reform proposal, the DSH formerly used for the IGT will instead be used to supplement the Medicaid expansion program for the three entities through their Hospital Trust Fund appropriation to hold them harmless.

The department is required to develop a new funding mechanism for the distribution of the DSH dollars. The new DSH program can be allocated to address uncompensated care at the three entities and to cover persons or services not covered by the Medicaid expansion.

Q 5: What is the role of Indirect Medical Education funding?

A: Currently, Iowa uses its federal Indirect Medical Education funding for an 'inappropriate' IGT through the UIHC, which results in revenue to the Medicaid Program of $18.4 million federal funds. Indirect Medical Education (IME) funds may be drawn down by states to provide additional reimbursements to medical teaching hospitals.

The IGT program is being eliminated by the federal government, so the IME funds will no longer be used for the IGT; however it is still available to Iowa for appropriate uses. Under the Iowa Medicaid Reform proposal, the IME formerly used for the IGT will instead be used to supplement UIHC and Broadlawns, as teaching hospitals (the MHIs do not provide medical education). The funds will flow through their Hospital Trust Fund appropriations to cover whatever the Medicaid expansion and DSH funding do not cover.

The department is required to develop a new funding mechanism for the distribution of the IME dollars in the same manner as the DSH funding discussed above.

Q 6: Will there be any changes to the Upper Payment Limit?

A: The Upper Payment Limit is the maximum reimbursement level allowed by CMS. The Upper Payment Limit is roughly equal to the Medicare reimbursement level. The Upper Payment Limit is the basis for the calculation used for the 'inappropriate' IGT payments for the Hospital Trust Fund and Senior Living Trust Fund IGTs that will be eliminated in this negotiation with CMS. Under the proposal, the Upper Payment Limit would be changed to reflect actual Medicaid costs rather than the higher Medicare level.

This is desired by CMS because it forecloses the opportunity for the State to develop new IGT type financing mechanisms.

Eligibility

Q 7: What population will be served under the new Program? What eligibility criteria will be used and who will determine eligibility?

Estimates put the number of uninsured adults under 200% of the Federal Poverty Level (FPL) not eligible for Iowa Medicaid at 147,000. There are a number of ways eligibility for the expansion Program can be addressed. Data would suggest this population would include:

- Childless or single adults (ages 19-64).
- Adults with Medicaid or hawk-i eligible children who make too much money to qualify for coverage themselves.
- Persons with disabilities who are not in institutions or accessing services through the home and community based waiver.

Eligibility for expansion could be established incrementally. For example, the State could choose to begin the expansion Program by extending eligibility to parents of children who receive Medicaid. Criteria for eligibility would be established by policy direction and oversight from the Joint Medicaid Legislative Committee.

Eligibility will be determined by a state Income Maintenance workers, possibly out stationed at Broadlawns Hospital and UIHC.

Q 8: How many people will be served under the new Program?

The number of individuals served by the new Program would be driven, in large part, by available resources. Rough estimates are that as many as 100,000 Iowans (unduplicated) could receive services under Medicaid expansion over the next five years based on currently available revenue.

Q 9: How will enrollment be structured to assure expenditures and enrollment remains within the caps? Is this an entitlement program?

A: A Joint Legislative Medicaid Committee would be appointed to continually review expenditures and eligibility to ensure services to the expansion population would not exceed available resources. The Committee would not be authorized to assume enactment of supplemental appropriations for the expansion population. The expansion population would be defined by a unique Medicaid waiver that would allow for limits on enrollment, eligibility, and services and provider network.

The expansion Program is not an entitlement. Eligibility and services can be adjusted at any point based on available resources and policies.

Q 10: What services will new enrollees be eligible for?

Initially, new enrollees would be eligible for inpatient/outpatient hospital services at Broadlawns, University of Iowa hospital or one of the four state Mental Health Institutes and physician services provided through those institutions. Later phases would include preventative care targeted at innovations in improving the health of Iowans.

Q 11: What happens to people not covered by the new Program?

People not served by the new Program would receive services much in the same way they do today. In Iowa's present health care system, these individuals represent uncompensated care and they will continue to represent uncompensated care in the new system. The new Program may identify additional resources already being expended on these individuals that could be matched under this initiative in the future.

Q 12: How will the Medicaid expansion work in Polk County versus the rest of the State?

Residents of Polk County who qualify for the Medicaid expansion program will access appropriate services at Broadlawns Hospital. Polk County residents who are eligible for the new Program, but who have tertiary medical needs could also access their care at the UIHC.

Provider Issues

Hospitals

Q 13: What happens to the State Papers / Indigent Care Program?

A: Policy changes may need to be made to the state papers/indigent care program. The goals are that people who receive care under this program continue to receive care while maximizing federal participation and exploring innovations in health care delivery.

Q 14: What happens to Broadlawns property tax levy?

A: The Broadlawns property tax levy generates approximately $44.2 million, of which $27.8 million comes from their General Fund levy and the remainder comes from other types of levies for FICA, IPERS, etc. The concept behind the proposal is for Broadlawns to transfer $34 million of their levy (the final amount has not been determined) to the Hospital Trust Fund to be used as State match for the Program. The proposal does not change the levy caps or rates.

Q 15: What will be the impact on hospitals not included in the Program?

A: There is no direct affect on hospitals who are not providers under the Program. Hospitals currently receiving DSH dollars will continue to receive them. At some point they may become eligible to provide services to the expansion population to the extent that population is currently provided with uncompensated care.

Nursing Facilities

Q 16: Why give up the Nursing Facility Tax (also known as Quality Assurance Fee)?

A: In the state's negotiations with CMS, Secretary Michael Leavitt clearly expressed a prohibition of provider taxes under the new waiver. In his letter to Governor Tom Vilsack dated March 22, 2005 he writes, "*I have directed CMS to work with you on the necessary terms and conditions of a waiver that will permit us to provide Iowa with the necessary flexibility to reform its Medicaid program. These terms and conditions will include positive steps to bring the State's financing of the Medicaid program into compliance and a prohibition of provider taxes for the duration of the waiver.*"

Q 17: Why should the State adopt a higher level of care for nursing facilities than the Home and Community-Based Services Waiver?

A: Under the current system an elder Iowan can only access home and community based waiver services if they are also eligible for nursing facility level of care. Most parties agree that there is a subset of the nursing home population that requires lower levels of care and could be served in their homes or other community settings. In addition, "rebalancing" the long-term care system has long been a goal of the Legislature and the Executive Branch. The proposal will further that goal by making it more difficult to enter a nursing home and encourage the development of and utilization of home and community based services.

Q 18: What will happen to residents of rural or other underserved areas if home and community-based services are not available and they do not meet the higher level of care required for nursing facility services?

Older and disabled Iowans Iowans, who do not have access to appropriate community based services in their community, could access nursing facility care if they meet the criteria established for home and community based waiver eligibility. Generally, these criteria are; 1) hands on assistance on a daily basis with one to three activities of daily living 2) a safe and secure environment for individuals who are chronically confused or mentally ill.

The impetus behind the differential criteria for admission to a nursing facility and access to waiver services is to promote community based options for elder Iowans so they can remain in their homes and communities.

The General Assembly is acting on legislation, HF 786 and SF 303, that would authorize nursing facilities to expand their operations to other activities or businesses in recognition of the need to diversify in anticipation of this change.

Q 19: Will anyone currently in a nursing home or served by one have to move or lose coverage?

A: No. Any individual currently residing in nursing home would not be affected by the differential between admission to a nursing facility and eligibility for home and community based services. This criteria would apply only to people going forward.

Physicians

Q 20: What are the provider incentives mentioned in the proposal?

A: This program would not be part of the first year implementation. It is scheduled for the second year. The concept is to develop payment incentives for physicians and other providers for an active primary care case management or medical home program.

Other

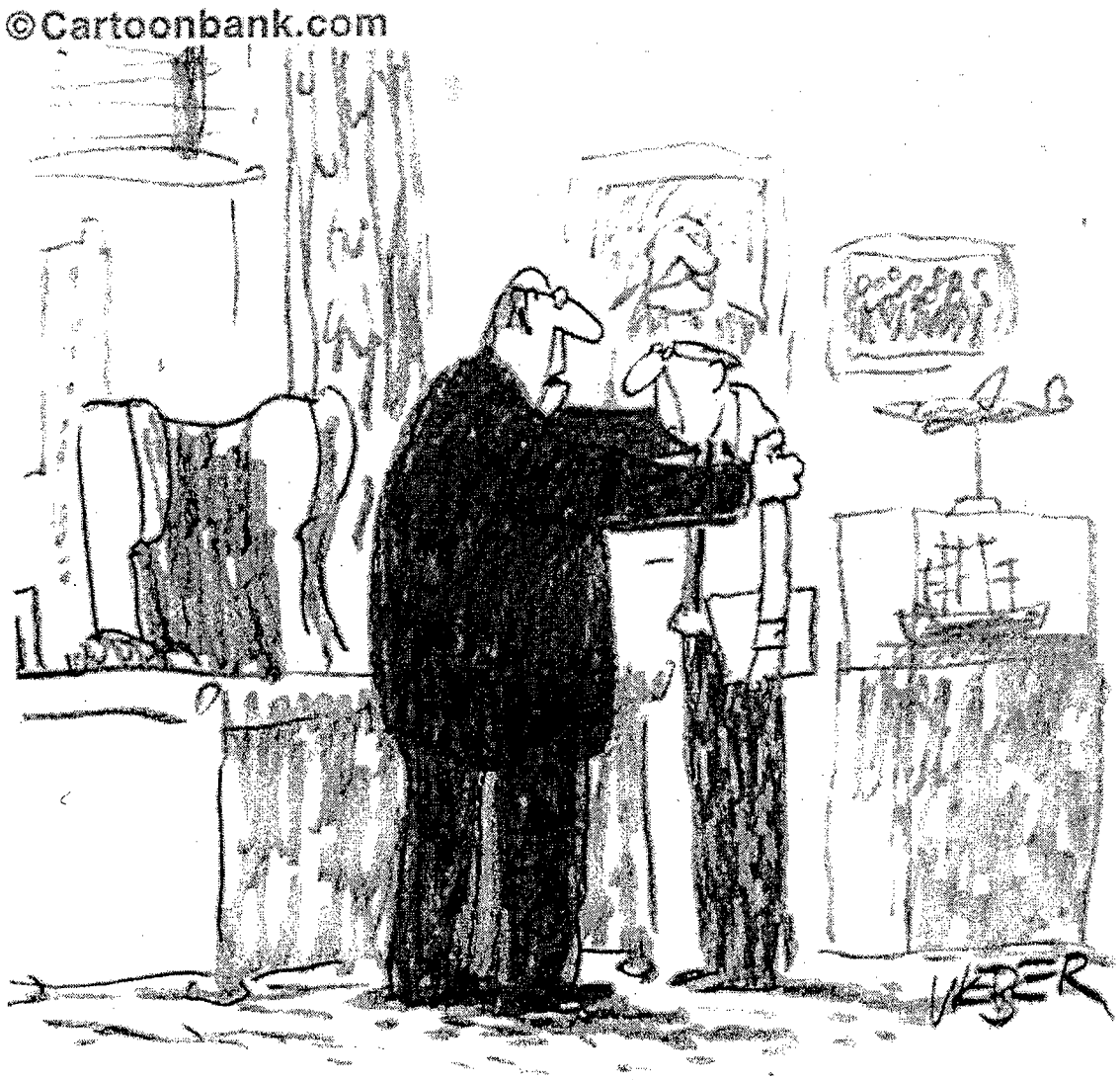
Q 21: Who will serve on the legislative committee and the medical services utilization and provider rate committee?

A: The membership has not yet been determined.

Q 22: Will the reimbursement rate information required by the rate setting commission from insurers and providers be kept confidential? Who will have access to the information?

A: Yes. Only the members of the commission and DHS staff directly providing support to the Commission would have access this information and would be obligated to keep this information in strictest confidence. This is similar to the arrangement used for the rebate information provided to the Pharmaceutical and Therapeutics Committee that administers the Preferred Drug List. This information is also considered to be highly sensitive and confidential.

Iowa Medicaid Initiative



"It's up to you now, Miller. The only thing that can save us is an accounting breakthrough."

Iowa Medicaid Initiative

- **Goals**
  - Preserve Medicaid, Reduce the $65 M gap
  - More Federal Dollars for Health Care
  - More personal responsibility, ownership of health care
  - Re-balance Long Term Care

Iowa Medicaid Initiative

- **Goal: Reduce the Gap**
  - How we got here
  - What happens if Iowa does nothing
  - Secretary Leavitt's Invitation to Act
  - Quick approval required

Iowa Medicaid Initiative

- **Goal: Reduce the Gap**
  - Iowa loses $65M in IGT.
  - Iowa converts Iowa tax dollars into Medicaid.
    - Using state/county funds to match feds.

Iowa Medicaid Initiative

- **Goal: Reduce the Gap**
  - Protect safety-net hospitals, MHIs
    - U of I Hospitals and Clinics
    - Broadlawns
    - Four MHIs

Iowa Medicaid Initiative

- **Goal: Introduce Limited Medicaid**
  - Expand Medicaid to 200% FPL
  - Not an entitlement
  - Coverage limited to services provided by safety net hospitals

Iowa Medicaid Initiative

- **Goal: Introduce Limited Medicaid**
  - Who will be covered, examples:
    - Parents of ***hawk-i*** kids
    - Childless/single adults

Iowa Medicaid Initiative

- **Goal: More Ownership of Health**
  - Premium cost sharing
  - Incentives:
    - To stay healthy
    - To avoid ER
    - To quit smoking

Iowa Medicaid Initiative

- **Goal: More Ownership of Health**
  - Expansion population pays monthly premium:
    - No more than 1/12 of 5% family income
    - Must pay at least four months

Iowa Medicaid Initiative

- **Goal: More Ownership of Health**
  - Develop Health Care Accounts
  - Help employees pay for employer insurance

Iowa Medicaid Initiative

- **Goal: Rebalance Long-Term Care**
  - Relief from rigid federal rules regarding nursing homes
    - Keeps more people in own homes/communities
    - Slows rate of cost growth
    - Expands Home and Community Based waiver

Iowa Medicaid Initiative

- **Advantages of Iowa Medicaid Initiative**
  - Reduces the $65 Million Gap
  - Expands Coverage for the Poor
  - Requires More Ownership of Health
  - Avoids Institutionalization when not needed

Iowa Medicaid Initiative

- **Advantages of Iowa Medicaid Initiative, cont.:**
  - Treats Medicaid like a business
  - Includes careful monitoring
  - Non-partisan problem-solving