IOWACARE RENEWAL

Presentation to the Health and Human Services Appropriations Subcommittee

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Why do we have IowaCare?

- In 2005, Federal action to eliminate $65 million in federal revenue from Intergovernmental Transfers (IGTs).
- Represented over 10% of Medicaid funding. Due to General Fund pressures at the time, this would certainly have resulted in program/provider cuts.
- IowaCare was developed to offset that loss.

Why do we have IowaCare?

- IowaCare converted long standing State/County funded indigent care programs at Broadlawns and Univeristy of Iowa Hospitals and the 4 State MHIs to a limited benefit Medicaid program.
- The 100% state/county funding was converted to a program that received 2/3 federal match. The "savings" went to the General Fund to offset the loss of federal IGT funding.
- Prevented significant program/provider cuts in the Medicaid program.

IowaCare Program – Limited Benefit Medicaid Expansion

- Eligibles = Adults age 19-64 below 200% FPL, 200%-300% pregnant women, former state papers grandfathered.
- Services = Inpatient, outpatient hospital, physician, limited dental and transportation.
- Providers = ONLY at UIHC, Broadlawns, MHIs (because their GF/County dollars funded the program).
- Designed to roughly match the prior 100% state/county funded programs.
- Sliding scale premiums – originally 10% FPL up, changed to 100% FPL up.

Financing

- FY 2009 total program expenditures are roughly $110 million (state and federal match combined).
- State Share (about $42 M) is primarily non-General Fund
  - $34 M Broadlawns Polk County property tax funds,
  - $3 M Health Care Transformation Account,
  - $4.6 M General Fund

Planned vs. Experience

- Planned to cover about 14,000 Iowans / enrollment now over 27,000.
- Unduplicated members since program inception over 57,000.
- Most of growth in services at UIHC.
- MHI payments of $24.8 M phased down to $9 M in FY 09, to $0 in FY 10 (per Federal Terms and Conditions).

1115 Waiver

- Under federal rules Medicaid covers individuals in certain categories – children, parents with dependent children, disabled, elderly, pregnant women.
- Single adults, couples without dependent children are not included
- "1115 Waiver" – Allows CMS to "waive" the regular Medicaid rules – i.e. cover populations not within federal categories, or limit services or access, such as managed care.

1115 Terms and Conditions

- 1115 Waivers must be "budget neutral" – meaning the waiver does not spend more federal dollars than without the waiver.
- Functions as a federal cap on spending.
- CMS approves waiver terms, but White House Office of Management and Budget (OMB) determines neutrality.
- IowaCare 1115 budget neutrality – premised on exchanging the federal IGT dollars for 1115 waiver.

1115 Waiver Renewal

- Waiver expires June 30, 2010.
- 1115 waivers are negotiations between the state and federal government.
- The negotiation is with several interested parties in the federal govt., each with different roles/ perspectives/objectives – there is CMS State Medicaid Operations, the Secretary of HHS, and OMB.

Waiver Renewal

- All of the key people we worked with on the original deal are gone.
- New administration, no appointments to key positions. We don't know yet with whom we will be talking.
- It is NOT a given that we will get the same deal on budget neutrality.
- There may also be new opportunities in given the national health care reform discussion.

Waiver renewal – expansion?

- There are many competing demands for expansion:
  - Continued growth in uninsured adults/need for coverage (large number of Medicaid/hawk-i parents uncovered).
  - Need for prescription drug, DME coverage under IowaCare.
  - Local access to local physician/hospital care
  - Better coverage for dental, and outpatient mental health.

Constraints

- Budget Neutrality
- Always need the State match – where will it come from?
- We believe the more difficult geographic access has constrained program growth – how big would the program be with better local access and better coverage?
- In a world of scarce resources we have to set priorities – what will they be?