Policy Brief

IowaCare: Need for Caution

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Iowa Fiscal Partnership

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By Charles Bruner, Victor Elias and Kelli Soyer

Synopsis

Faced with the potential loss of $65 million in federal Medicaid Intergovernmental Transfer (IGT) funds for the 2005-06 fiscal year, Iowa policy makers took action. They successfully negotiated a Medicaid waiver with the Centers for Medicare and Medicaid Services (CMS) which enables the state to continue to receive up to $65 million in federal funds, through a new program called IowaCare. While this program has been hailed as an expansion of health coverage to 30,000 more low-income Iowans, it really only maintains Iowa's current publicly supported health services, although it does restructure them.

At the same time, IowaCare could result in some adverse consequences – both to low-income Iowans needing medical care and to the medical institutions providing that care. The potential negative effects are the result of provisions in the new program that do not apply to other Medicaid participants – premium payment requirements, restrictions on provider choice, limitations on health benefits, and capitation that could limit access based upon funding and not eligibility.

In its simplest terms, IowaCare substituted one accounting mechanism to draw down federal funds for another accounting mechanism that Iowa had been employing but CMS was disallowing. Gaining federal approval, however, required accepting additional provisions that could prove problematic. Implementation of IowaCare requires careful monitoring and oversight and potentially timely corrective action to address unanticipated adverse impacts. As structured, IowaCare should not be viewed as a model for national health-care reform efforts nor should its provisions be considered as appropriate for adoption to the larger Medicaid population.

Introduction

During the 2005 legislative session, the Iowa General Assembly adopted HF841, providing legislative authority for a major Medicaid waiver changing significant aspects of both the Iowa Medicaid program and several other public programs providing health services to low-income Iowans. The Iowa Department of Human Services successfully negotiated the waiver with the federal Centers for Medicare and Medicaid Services (CMS). The result has been hailed by many in Iowa as a model for the country in reforming Medicaid.

The legislation and waiver contain two major components: a limited expansion of the Medicaid program called IowaCare and a package of health transformation initiatives. The IowaCare program began on July 1, 2005. Most of the health transformation initiatives begin in 2006 or 2007, except for the Medicaid Enterprise and some changes to nursing home reimbursement.

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The IowaCare program was designed to prevent the loss of up to $65 million in federal Medicaid funds through federal disallowance of Iowa's intergovernmental transfer (IGT) system. It restructures both the eligibility and coverage system in Iowa related to individuals served at the University of Iowa Hospitals and Clinics, Broadlawns Medical Center, and the state mental health institutes. IowaCare is the subject of this report. This report suggests that, as currently structured, IowaCare should not be considered as a national model for changes to the general Medicaid program, although it may represent a good negotiated agreement to preserve needed federal funding for low-income Iowans. It also points to areas where IowaCare may need to be modified (particularly around premiums and co-payments) if it is to meet the health needs of the population it serves.

The health transformation initiatives also include other additional federal funding and provide for the following changes to Iowa's Medicaid system.[1] Many of these transformations represent positive changes that, if implemented effectively, can serve as national models. These are not discussed in the body of this report, but are described very briefly below:

Provisions implemented in 2005:

- The Medicaid Enterprise, which consolidates the administrative functions of the Iowa Medicaid program within one location to provide for more efficient administration. The Department is seeking Joint Commission on Accreditation of Health Care Organizations (JCAHO) accreditation for the Medicaid Enterprise. Included within the Medicaid Enterprise is a Clinicians Advisory Panel to make recommendations on clinically appropriate health care utilization and a Health Care Services Pricing Advisory Panel to make recommendations on pricing of Medicaid services.
- Level of care requirements for nursing facilities for persons newly entering those facilities.
- A waiver enabling up to 300 children with mental health diagnoses to receive Medicaid services without their parents having to relinquish custody to the Department of Human Services for placement into foster care.

Provisions to be implemented by July 2007:

- Case mix reimbursement rates for intermediate care facilities for persons with mental retardation (ICF-MRs), a plan for reducing placement at state-operated and community-based ICF-MRs, and a requirement to provide a health assessment for all persons with a developmental disability
- An electronic medical records system for all Medicaid recipients that is portable with the individual
- Incentives for medical practitioners to use evidence-based treatments
- Dental homes for all Medicaid children under the age of 12
- Financial incentives for small businesses to provide health insurance to their employees
- A strategy to provide dietary counseling to assist Medicaid patients with weight loss
- A program to reduce smoking among Medicaid enrollees, with a goal that less than 1 percent of Medicaid children and 10 percent of Medicaid adults smoke.

Again, the remainder of this report covers only the IowaCare portion of the waiver.

[1] According to a presentation given to the Iowa Human Needs Advocates on September 16, 2005, DHS Director Kevin said Iowa has received about $32 million in Medicaid funds to be used for health care transformation over the next five years.

IowaCare Basics

Faced with the potential loss of $65 million[2] in federal Medicaid Intergovernmental Transfer (IGT) funds for the 2005-06 fiscal year, Iowa policy makers took action. They successfully negotiated a Medicaid waiver with the Centers for Medicare and Medicaid Services (CMS) which enables the state to continue to receive up to $65 million in federal funds, through a new program called IowaCare.

In July, Iowa launched IowaCare, offering limited Medicaid coverage to Iowans, primarily to persons who previously had received free health services through state-only or county-only funds. As a program, IowaCare does not increase public funding for health care beyond what was available in 2004-05, but it does restructure the way some of the current care is provided in order to draw down Medicaid funds that would otherwise have been lost through disallowed IGTs. As part of obtaining federal approval, IowaCare also imposes new financial obligations on low-income Iowans who previously had been served by state-only or county-only funds.

The IowaCare program has been promoted as an expansion of health coverage for low-income Iowans and a potential model for adoption throughout the country. Press reports have hailed IowaCare as "providing Medicaid to 30,000 more Iowans." This statement, however, is misleading. People who had been receiving health care through other public funding sources now will be enrolled in IowaCare and eligible for Medicaid reimbursement, but this does not expand the total amount of publicly-financed health care provided to low-income Iowans -- it merely shifts who will be paying for that specific care.

Iowa policy makers deserve to be applauded for establishing IowaCare to retain the majority of federal IGT funding under Medicaid that might otherwise have been lost. At the same time, IowaCare contains some provisions that could prove problematic to providing affordable health care for those it is designed to serve. It should not be considered a model for adoption in other states or inclusion in changes to Medicaid currently being considered by the United States Congress. The impact of IowaCare on the patients it serves needs to be placed under careful scrutiny and oversight even for the limited population it is designed to serve.

It is important to place these notes of caution on IowaCare for two reasons. First, at the state level, IowaCare may require significant modification if it is to achieve its own objectives. It is a new and untested approach to serving the health needs of a population previously served under long-standing state or county programs. Second, IowaCare is a program designed to serve a very different population from the traditional Medicaid population. It should not necessarily be considered as an approach applicable to the Medicaid population as a whole, even if it can be made to work for the targeted population served in Iowa. In simple terms, IowaCare establishes a new accounting mechanism to draw down Medicaid funds to replace an accounting mechanism that the federal government is disallowing. This new mechanism came with some strings attached. These strings are problematic for the special population being served under IowaCare, and could be very detrimental if applied to the general Medicaid population, particularly children and families needing primary and preventive health care services.

2 The Iowa Department of Human Services states the lost IGTs at $65 million, most recently in their August 31, 2005, presentation to the Legislature's Medical Assistance Projections and Assessment Council by DHS Director Kevin Concannon and Medicaid Director Eugene Gessow. The IowaCare funding structure described here has been presented as capable of retaining most or all of this funding, although it alone is unlikely to retain the full $65 million.

The Medicaid Program

The Medicaid program is a state-federal partnership to provide health care to specific vulnerable populations, based upon their income and resources. This includes children, persons with disabilities eligible for supplemental security income (SSI), low-income seniors (for services not covered by Medicare), and parents of children who qualify under circumstances related to the Temporary Assistance To Needy Families (TANF) program. The Medicaid program initially tied child eligibility to welfare eligibility, but subsequently broadened child eligibility to cover children, at state discretion, up to 185 percent of poverty.

Under federal requirements, states can determine the scope of health benefits, but they generally must be fairly comprehensive. States can impose modest co-payments for some services (such as prescription drugs), but cannot charge premiums for participation. There are no allowed co-payments for children. By far the largest numbers of Medicaid recipients are children, but children constitute a very small percentage of Medicaid costs. Medicaid covers long-term care for both seniors and persons with disabilities; such care constitutes the largest share of Medicaid expenses.

Once eligibility standards are determined, states must serve all individuals who qualify under those standards, and are found to be in need of eligible services provided by an eligible provider. The federal government participates in paying these costs on a matching basis, which varies from 50 percent to 80 percent, depending upon state income. For 2005 Iowa's federal Medicaid matching rate currently is 63.55 percent, meaning that the federal government pays 63.55 percent of Medicaid claims.

Medicaid has not covered most 19-64 year-olds, unless they meet definitions of being children, parents of children eligible under TANF, or persons with disabilities eligible under SSI. Single adults and childless couples are categorically excluded, even if they have significant mental health, substance abuse, or physical disabilities that do not qualify them for SSI. The Iowa Medicaid waiver (IowaCare) would make a select group of these currently categorically ineligible adults eligible for Medicaid.

Background – The Structure of the Waiver Agreement

IowaCare was the result of a complicated negotiation between Iowa policy makers and the Centers for Medicare and Medicaid Services (CMS).

Like most states, Iowa had developed a number of accounting practices designed to draw down federal Medicaid funds to maintain their state Medicaid programs, particularly in light of rising health-care costs. One of the practices adopted in various forms in many states was the establishment of Intergovernmental Transfers (IGTs). IGTs transfer public funds used to provide medical services (often considered charity care) to the state. At the same time, the state Medicaid program increases its reimbursement rate for the Medicaid patients under the care of those receiving the public funds in an amount equal to the transferred funds. The result is that the same amount of money is available to the public entities to provide services, but a greater share of that funding draws down federal Medicaid funds. In Iowa, the federal government pays 63.55 percent of most Medicaid claims. Therefore, for every dollar that is part of an IGT, an additional 63.55 cents in federal Medicaid funding is received. Iowa had drawn down approximately $65 million annually in increased federal Medicaid funds through IGTs.

CMS has been trying to curtail the use of IGTs by states and has identified Iowa's IGT program as not eligible for federal matching funds. CMS notified Iowa officials that Medicaid would not permit Iowa to draw down federal funds for its IGTs after June 30, 2005. The state had three options available: (1) to accept CMS's decision and lose the $65 million for future years; (2) to contest the decision through the administrative and legal process, which could take years to resolve; or (3) to negotiate a new arrangement with CMS that would retain as much as possible of the $65 million.

The Iowa Department of Human Services elected the third option and worked with legislators to develop a program that would maximize 100 percent state and county funding by matching federal funding, submitting a proposal to CMS in the summer of 2004.

This alternative was in the form of a Medicaid waiver that would capitate (place a ceiling upon) the amount of funding Iowa would receive equivalent to what it was receiving under the IGTs. Federal Medicaid waivers must be revenue neutral in their expenditure of federal funds, but CMS agreed that this revenue neutrality could be based upon Medicaid expenditures that included the disputed IGT spending, provided an agreement could be reached prior to July 2005.

The Iowa Department of Human Services' proposal was to make use of a different pool of 100 percent state and county dollars which had been providing free care to Iowans through making individuals receiving those services eligible for Medicaid, and therefore federal matching funds. These included three separate pools of public funds:

- Much of the free care program serving indigent Polk County residents at Broadlawns Medical Center in Des Moines, through property tax dollars totaling $34 million in FY2005.
- The University of Iowa Hospitals and Clinics indigent patient program, a direct state appropriation to the University of Iowa of $27.3 million in FY2005, which allowed counties to send, under a "state papers" program, indigent individuals to the University of Iowa for care.
- Care provided at the state's four mental health institutes for individuals not currently eligible for Medicaid or Medicare, at $25.9 million.[3]

The participants in all three programs were currently receiving free medical care through public funding, but were not eligible for Medicaid. Most were in the 19-64 age category and did not meet the categorical definitions of eligibility for Medicaid (children, parents of children eligible for TANF or medically needy spend down, the elderly, or the blind and disabled). The waiver proposed to make individuals 19-64 and under 200 percent of poverty eligible for Medicaid, under the following conditions:

- The benefit package would not cover the full range of medical services available to other populations under Medicaid, but would be limited, largely to the same range of medical services they had received under the free care program (although some additional provisions have been added in);
- Freedom of provider choice would be eliminated for this group of Medicaid recipients who may have been ineligible for Medicaid benefits prior to the IowaCare Program and providers would be restricted to the University of Iowa, Broadlawns Medical Center, and the four mental health institutes;

[3] These figures are from a University of Iowa PowerPoint on IowaCare program issues. The three figures add up to $87.2 million, somewhat less than the $102.3 million of Medicaid claims needed to draw down $65 million in federal Medicaid funds.

- The amount of federal funding to be received for this population would be capped at $65 million,[4] and
- The state would be allowed to limit enrollment in order to manage the available funding instead of being required to enroll all individuals who met the new eligibility definitions.

At one level (see illustration), this proposal simply substituted one accounting mechanism (designating certain individuals as Medicaid-eligible) for another accounting mechanism (allowing IGTs).

As negotiations with the Iowa Department of Human Services proceeded, the Governor and state legislative leaders became involved. In the end, an agreement was reached between CMS and the state, and the General Assembly enacted and the Governor signed enabling legislation. This agreement also required those enrolled in IowaCare to pay a premium, which they had not had to do under the three prior public programs.

How IGTs and IowaCare Work: An Illustration

Both IGTs and IowaCare constitute accounting mechanisms to draw down additional federal Medicaid funding. To show how each works, the mechanisms are applied to a mythical medical institution with an overall $50 million budget, $10 million of which is from public funds for charity care, $20 million from insurance and other sources, and $20 million from Medicaid. These are simplified examples, but show the basic logic behind each approach.

IGTs. Under an IGT, the $10 million in public funds is transferred to the state. The reimbursement rates under Medicaid to the medical institution are raised by 50 percent (they must stay under a maximum allowable reimbursement rate for Medicaid) to provide $10 million in additional Medicaid revenue to the medical institution. The state of Iowa pays $3.645 million and the federal government pays $6.355 million of the new Medicaid funding. In the end, the medical institution still has a $50 million budget and the state has a net gain of $6.355 million in funds.

IowaCare. Under IowaCare, the $10 million in public funds also is transferred to the state. Rather than increasing Medicaid reimbursement rates, however, the patients who had been served with that $10 million in funds are made eligible for Medicaid in order to receive the same total amount of services. This $10 million in medical institution services now draws down $10 million in Medicaid funds, $3.645 in state dollars and $6.355 in federal funds. In the end, the medical institution still has a $50 million budget, and the state has a net gain of $6.355 million in funds.

In the illustrations, there is no change either in the operating budget of the medical institution or in the patients provided services or the services being provided. The only change is that federal financial participation is increased by $6.355 million and the state receives the benefit.

For enrollees with incomes below 100 percent of poverty, the premium was not to exceed 2 percent of family income. For enrollees with incomes between 100 percent and 200 percent of poverty, the premium was not to exceed 5 percent of family income. The premium provision, the capitation, the restriction on service provision to specific providers, and the limited scope

4 A better estimate of the funds that can be drawn down through the IowaCare claims, based upon prior claim volume, is more like $55.2 million, a figure presented in the Legislative Services Agency 2005 Session Fiscal Report (Graybook) fiscal analysis of the IowaCare Medicaid Reform Act, HF 841. The Department is working with Broadlawns Medical Center to seek to adjust the disproportionate share funding structure to drawn down additional federal funds.

of benefits all represent departures from existing Medicaid policy and practice for the general Medicaid population.

For Iowa to receive the full fiscal benefit of this agreement, there must be a newly enrolled population of Medicaid patients under IowaCare for whom providers receive $102.2 million in reimbursement for medical services. For the University of Iowa, Broadlawns Medical Center, and the four mental health institutes to fiscally balance the new Medicaid funding with their funding previously used to provide free care, they cannot be expected to provide more than an equivalent fiscal amount of services as they previously provided. These services do not have to be provided to the same set of patients served under the prior system, but the institutions cannot simply expand their service base without expanding the funding provided it. Moreover, they may have specific mandates that require them to continue to serve certain patients, regardless of whether they become Medicaid-eligible under IowaCare, as all hospitals are required to do under federal law.

Implementation Issues

As Iowa moves forward to implement IowaCare, there are four issues – from both a state fiscal perspective and a patient need perspective – that need to be given very close scrutiny. These are: (1) the impact of premiums; (2) the impact of restructuring the indigent patient program at Broadlawns Medical Center; (3) the impact of replacing the state indigent patient program at the University of Iowa with IowaCare; and (4) the impact of restructuring the mental health institute programs.

Premiums

The legislation and departmental rules call for all Medicaid recipients under IowaCare to pay a monthly premium for their care, based upon their income. Studies from Oregon and other states have indicated that, particularly for individuals with incomes below 100 percent of poverty, a premium requirement can substantially reduce enrollment, by as much as 40 percent.[5] Studies also have shown that even seemingly modest premiums for persons up to 200 percent of poverty can render significant hardships upon families, forcing them to choose between an array of essential needs (health care premiums, food, shelter, or utilities).[6] In particular, the monthly premium for a family of three with earnings at 120 percent of poverty ($19,308 a year or $1,609 per month) would be $43 per adult family member enrolled. If the household includes two adults and one child (who would already be eligible for Medicaid), the monthly premium would be $86. While a single adult with an income at 80 percent of poverty ($7,656 or $638 per month) would have a premium of only $11 per month, that still can be a burden, as well as administratively costly to collect. Given what is known about the individuals who were served by Broadlawns Medical Center, the University of Iowa, and the mental health institutes, it is likely that a very significant share of those who will be covered under IowaCare will have small and often sporadic incomes. Further, many will not have any way to pay premiums except by cash.

The IowaCare program does not require the premium payment for a 30-day period after enrollment, and initial care during that period will be provided and covered by Medicaid. Still, the

5 Ku, L. (2005). New research sheds light on risks from increasing Medicaid cost-sharing and reducing Medicaid benefits. Center on Budget and Policy Priorities, http://www.cbpp.org/7-18-05health.pdf

6 Wright, D. et.al. (2005). "The impact of increased cost-sharing on Medicaid enrollees," Health Affairs 24(4): 1107-15. Coughlin, T. (2005). "Assessing access to care under Medicaid: Evidence for the nation and thirteen states," Health Affairs 24(4): 1073-1082.

individual's continued coverage after that period is dependent upon paying that premium or declaration of hardship. If individuals lose enrollment in Medicaid due to their inability to pay premiums, this likely would have an adverse impact on Iowa's ability to recover the full $65 million in federal funds allowable under the waiver.

The premium provisions need to be monitored closely for the following potential adverse impacts:
1. The financial burden they may place upon individuals and their families and any increased chance they will forego needed care as a result of failure to pay the premium;
2. The administrative costs related to collecting the premium (particularly for persons below 100 percent of the poverty level) in relation to the premiums actually collected; and
3. The disenrollment rate due to failure to pay the premiums, and the impact of disenrollment on the ability of the state to draw down federal funds to make the system work.
4. Continual disenrollment of these patients will result in patients being much sicker when they finally present to the emergency room. Broadlawns Medical Center has turned over its tax levy used for this class of patients, but must provide these unfunded services to disenrolled patients when they present for services.

Impact Upon Broadlawns Indigent Care Program
Historically, Broadlawns Medical Center has provided indigent care to Polk County residents through a property tax levy of $34 million. This care has served residents who are otherwise uninsured and unable to afford care and includes primary and secondary health care services and psychiatric care. As a public hospital, Broadlawns has a statutory obligation to provide this care for Polk County residents and it currently covers individuals all the way up to 500 percent of poverty, with a sliding fee schedule starting at 200 percent of poverty.

Under the federal waiver, Broadlawns will transfer $34 million in property tax revenue to the state and be guaranteed, for the first year at least, $34 million in funding through Medicaid or state payment.

Broadlawns' overall FY2004 revenues were about $75.7 million. Broadlawns' $34 million in property tax revenues finances its indigent care program; the number of patients served under that program who will qualify for IowaCare Medicaid has not yet been determined. Currently, however, it is estimated that a significant share will not be eligible, either because they are part of the group with incomes over 200 percent of poverty who are now receiving care on a sliding fee basis, or because they receive psychiatric services, which are not part of the IowaCare service package for Broadlawns. Broadlawns will still be under an obligation to serve those patients, regardless of whether they are eligible for Medicaid. Polk County Health Services payments to Broadlawns for adult mental health services represents approximately 4 percent of Broadlawns' budget. The first year of implementation guarantees that Broadlawns will be held harmless and receive needed funding from the state to maintain these services, whether or not Medicaid provides matching federal funds.

For Broadlawns Medical Center, it is likely that the state will be able to generate federal Medicaid funds from only apportion of the $34 million in patient services previously provided through property taxes, which could make it unlikely for Iowa to secure the full $65 million in federal funds to replace the loss from the IGTs. Further, Broadlawns cannot simply enroll new

patients under these guidelines to draw down additional federal funds, because this would not increase its overall funding base to accommodate the additional services it would be providing.

As the implementation proceeds at Broadlawns, there will need to be an examination not only of Medicaid enrollment under IowaCare, but also the provision of services to individuals who do not qualify for IowaCare and the overall impact upon Broadlawns' operating budget and service provision. Early implementation experiences (see Box on page 10) indicate the need to act expeditiously to correct potential problems and unanticipated consequences.

Impact upon University of Iowa Indigent Care Program

The indigent care program at the University of Iowa, which IowaCare replaces, has had a rich history. It has provided care for people throughout the state and contributed to medical education in the process. Counties were allotted specific numbers of individuals they sent to the University of Iowa under the indigent care, or "state papers" program, each year. The University of Iowa provided transportation for these patients to the University, often housed them while they awaited care, and addressed their specific health care needs. The University of Iowa is a tertiary care facility and provides medical care that is not available in many parts of the state. While some patients used the "state papers" program for chronic health care issues, many were seen for a specific medical treatment and not for ongoing medical coverage and care.

County relief directors typically have sent uninsured patients to the University of Iowa for high cost medical procedures that otherwise would be a major charge on charity and bad debt, if they could be provided through the county hospital at all. These patients include single adults with very few resources. While the state has provided $27 million annually for the indigent patient program, the University of Iowa has contended that the services provided under that program far exceed that amount. The state papers program is based on numbers of participants and not medical charges; physician services are provided without charge since they are already paid faculty members within the College of Medicine.

Under IowaCare, there no longer are specific allotments of patients to counties. The first effort to enroll IowaCare patients for health services at the University of Iowa has been through a mailing to patients who received care in previous years (1,800 of the 4,000 patients returned applications). This is a very different structure for selecting patients and could result in a very different patient base, particularly if the individuals enrolled are expected to continue to receive medical care at the University of Iowa throughout the year. Further, it is not clear whether patients who do have major medical needs that previously would have used the state papers program will be enrolled or how that enrollment process will work. Those with a chronic condition were allowed to continue to receive care at the University of Iowa under the IowaCare Program. Those who had appointments already scheduled for July and August 2005 were allowed to keep their appointments, independent of eligibility for the IowaCare Program. County relief directors made decisions on how to use their state papers allotments in order to have slots available to handle high cost and tertiary care needs, regardless of when they arose during the year. The University of Iowa allowed counties to switch a more costly later-in-the-year patient with a less costly earlier-in-the-year patient within the quota system, to accommodate counties that may have exceeded their quota. The University of Iowa also permitted counties to share quotas. The replacement of the state papers program with IowaCare changes these dynamics and places a premium on getting individuals enrolled before a statewide capitation is reached. This conceivably could lead to a situation where a

patient with a more critical problem is denied care simply because the patient became ill too late in the year, or, alternatively, becomes a county funding liability.

For the University of Iowa to continue to receive the same revenue as it has received under the state papers program, it will need to receive $27 million in funding through IowaCare. Even if that is achieved, however, that may not equal the amount of care that the University of Iowa actually provided under the state papers program, nor the actual specialized patient volume for its medical education.

As implementation proceeds, there will need to be very careful examination of:

- how enrollment is conducted and the degree to which counties still can ensure that patients previously receiving state papers can secure needed care, particularly the type of tertiary care provided at the University;
- the implications of using IowaCare as an ongoing medical program at the University of Iowa for patients from around the state;
- the overall impact on the provision of medical services at the University of Iowa; and

Early Experiences with IowaCare

Tarin A, a child care worker in Wellman, Iowa, applied for IowaCare and paid a $44 monthly premium for three months while attempting to get health coverage under the IowaCare program. She was repeatedly frustrated by her inability to obtain information that would enable her to schedule a health check-up or to get a clear picture of the health benefits to which she was entitled. When she called the IowaCare numbers, she either received a taped message (where she left messages that were not returned) or was referred to a person who did not have information that could answer her questions. She pursued IowaCare because she was uninsured and believed that there were a limited number of slots available and she should enroll quickly. Tarin was willing to have her health services provided through the University of Iowa Hospitals and Clinics, although that may not have been her first choice of care. Despite persistent efforts to gain information that would enable her to access health coverage when she needed it, she was unable to obtain basic coverage and access information. In September, IowaCare informed her that she would be dropped from coverage if she did not pay her current premium. She has requested a refund of her prior premium payments.

* * * * *

Kayleen S had been a patient under the state papers program for treatment and recovery from cancer and other health conditions prior to IowaCare. She works as a teaching assistant and also cares for her elderly mother. Earning approximately $16,000 annually, she enrolled in IowaCare to cover her ongoing medical costs, which previously had been fully covered under the state papers program. She has taken the hardship exemption to avoid the premium assessment to her of $43 monthly, which she felt she would not be able to pay without giving up necessities. She must sign and return a statement each month in order to continue as a hardship case and avoid the monthly premium.

Kayleen has found, however, that IowaCare covers only nine of her prescription medications. The co-payments on those prescriptions are $18 per month, alone (which she received without co-payment under the state papers program) but the cost of six other prescriptions is $285, which she has had to pay herself. In essence, the switch from the state papers program to IowaCare has resulted in increased out-of-pocket medical expenses to her of over $300 per month.

■ the impact upon county hospitals and county budgets of being expected to provide services to patients who previously have been served through the state papers program but who may not be served under IowaCare.

Impact Upon Mental Health Institutes

The impact upon the four mental health institutions may be less in terms of patient provision of services, as the likely population base of patients served will not necessarily change, and it is simply a matter of making as many of those patients as possible eligible under IowaCare. Again, however, the premium requirements could result in the disenrollment of some of the patients, at a lost opportunity for the state to draw down the expected federal funding.

First Signs and Issues

Early implementation experiences with IowaCare have raised significant issues that, if broad-based, require expedited corrective action. At the beginning of October, over 700 persons who had enrolled in IowaCare were disenrolled for not paying their premiums, approximately 300 from Broadlawns Medical Center. This was the first month for disenrolling IowaCare participants, which will occur monthly. The health conditions of these individuals and the reasons they did not pay their premiums need to be explored.

In addition, the box shows the experiences of two individuals who sought to make use of IowaCare to cover their medical needs. In both instances, IowaCare did not provide them with the types of health-care coverage that they expected or that would be needed to provide for good health insurance.

Conclusion

The Iowa legislation authorizing IowaCare calls for ongoing program evaluation and establishes a legislative committee to provide oversight. This paper has suggested the types of examination of the program that need to occur. These examinations can and should be initiated very early in the process of implementation. Examining a cohort of individuals initially enrolled can provide information on the impacts of the premium provisions on both continued enrollment and on the ability of those individuals to meet family needs. Comparisons of initial cohorts enrolled by provider institutions with historical information on clients served in previous years can identify the impacts on those institutions and changes in the focus of services being provided, if any.

Independent review of the effects felt by a first cohort of enrollees should be conducted very early in the implementation period – with some initial reporting available by the end of October (when the first impacts of the premiums upon continued eligibility will be felt, as this is the time that persons who fail to pay premiums will be disenrolled). This is important so needed corrections can be made to ensure that:

■ expected federal funds are drawn down,
■ health care needs met by the prior programs are still being addressed,
■ individuals are not being overly burdened by the new system providing their medical care, and
■ the institutions involved can fiscally and programmatically manage under the new provisions.

This includes an analysis of the actual patient population served by IowaCare in comparison with the patient population served under prior programs, to determine if there are any changes or gaps in service to specific populations.

If implemented with oversight and necessary modifications, IowaCare may prove to be a good and workable Iowa solution to the disallowance of IGTs by CMS. At the same time, it does not reflect an approach to substantially broadening health coverage to a previously uninsured and unserved population, nor are its special provisions necessarily applicable to the rest of the Medicaid population.

Therefore, the IowaCare program should not be used as an example of Medicaid reform that should be a model to the country or that should be extended to the Medicaid program as a whole. Both the National Governors Association and the U.S. Congress are examining ways to contain Medicaid costs, including some of the features of IowaCare. Extending any of these provisions at this time – premium requirements, limited benefits, and restriction of provider choice – to other parts of the Medicaid program based upon IowaCare is unwarranted. In particular, the role of Medicaid in improving the health of this country's most vulnerable children would be seriously jeopardized if such provisions were to apply to children served under Medicaid.

Meeting IowaCare Goals: Summary of Key Implementation Issues

 # Goal
- Requirements to achieve goal
  - *Issues in implementation*

1. Preserving $65 Million in Federal Medicaid Funding

- Requires producing new Medicaid claim volume of $102.2 million from current state/county service provision
  - *Identified state/county claims with potential Medicaid match could be $70 million or less, well below the amount needed to reach full draw-down of funds under the agreement*

2. Retaining Institutional Integrity

- Requires meeting the patient service responsibilities of the institutions (Broadlawns Medical Center, University of Iowa, MHIs, and Public Hospitals) within new IowaCare framework
  - *Broadlawns must continue serving current Polk County indigent patients, even if they do not qualify under IowaCare, while Broadlawns does not receive funding to expand service provision*
  - *Counties and the University of Iowa continue to have responsibility to meet tertiary care needs of indigent patients but do not have state papers program for such care*

3. Meeting Indigent Patient Care Needs

- Requires ensuring that IowaCare does not impose hardships or restrict access to care
  - *Other states' experience and current patient profiles suggest IowaCare premium structure, particularly for those below 150 percent of poverty, may: (1) limit enrollment and ability to draw down federal Medicaid funds, (2) result in hardship to indigent patients served, and (3) provide little, if any, net new revenues due to administrative costs*
- Requires ensuring that IowaCare provides care to those who most need it
  - *Elimination of University of the Iowa indigent patient program could disrupt the provision of tertiary care*
- Provides opportunity for serving more uninsured Iowans
  - *Capitation, restriction of provider choice, limitation on benefits, and state financial investment limit ability to provide additional meaningful coverage*

Iowa Fiscal Partnership

The Iowa Fiscal Partnership is a joint initiative of the Iowa Policy Project and the Child & Family Policy Center, two nonprofit, nonpartisan Iowa-based organizations that cooperate in analysis of tax policy and budget issues facing Iowans. IFP reports are available on the web at http://www.iowafiscal.org.