OFFICE OF AUDITOR OF STATE
STATE OF IOWA

David A. Vaudt, CPA
Auditor of State

State Capitol Building
Des Moines, Iowa 50319-0004

Telephone (515) 281-5834 Facsimile (515) 242-6134

NEWS RELEASE

Contact: David A. Vaudt
515/281-5835
or Tami Kusian
515/281-5834

FOR RELEASE February 15, 2013

Auditor of State David A. Vaudt today released a report on the IowaCare program (IowaCare) administered by the Iowa Medicaid Enterprise, a division of the Department of Human Services (DHS-IME), for the period July 1, 2009 through June 30, 2012. The review was conducted in conjunction with the audit of the financial statements of the State of Iowa and in accordance with Chapters 11 and 249J of the *Code of Iowa* to determine if IowaCare was administered in compliance with applicable laws, rules and guidelines and also to determine if IowaCare is meeting the program purpose and goals.

IowaCare was established in accordance with section 1115(a) of the Social Security Act through a Medicaid waiver granted by the Centers for Medicaid and Medicare Services for the period July 1, 2005 through December 31, 2013. IowaCare was established by Chapter 249J of the *Code*, the IowaCare Act, to provide limited Medicaid benefits to eligible individuals obtaining services from a participating provider in the IowaCare network, which currently consists of Broadlawns Medical Center, the University of Iowa Hospitals and Clinics and 6 Federally Qualified Health Centers located throughout the State. Initial enrollment projections calculated by DHS-IME in fiscal year 2006 estimated IowaCare would serve approximately 14,000 participants.

Eligibility for IowaCare is primarily based on household income as a percentage of the federal poverty level (FPL) established annually by the U.S. Department of Health and Human Services. To enroll in IowaCare, individuals must submit an application to DHS for approval. Application information is self-reported and is not consistently verified by DHS.

Vaudt reported IowaCare enrollment was 60,703 as of June 30, 2012, an increase of 42,661, or 237%, over the enrollment of 18,042 as of June 30, 2006, the initial year of IowaCare. This significant increase was primarily due to the expansion of the IowaCare provider network and the addition of new services, such as emergency services available through non-participating providers, radiology and laboratory services and care coordination, during fiscal years 2010 through 2012. During fiscal year 2012, a total of 86,802 participants received services under IowaCare.

Vaudt also reported total revenues recorded in the IowaCare Account Fund increased from approximately $97 million in fiscal year 2006 to approximately $141.8 million in fiscal year 2012, an increase of approximately $44.8 million, primarily due to increased federal funding received as

a result of the increased number of IowaCare participants and the expansion of the provider network and services.

Premiums are assessed to IowaCare participants based on income as a percentage of the FPL. However, participants who are unable to pay their monthly premium, in part or entirely, may request a hardship exemption by submitting a written statement declaring the monthly premium would be a financial hardship. Vaudt reported total premiums billed to participants decreased approximately $2.3 million from June 30, 2010 to June 30, 2012, with the average monthly premium billed per participant decreasing by $49, from $67 to $18. The significant decrease in total premiums billed occurred despite the significant increase in enrollment, primarily due to the adjusted FPL percentages at which no premium is assessed to IowaCare participants. Effective October 1, 2010, the minimum FPL percentage used to determine the assessment of premiums increased from 110% to 150%. In addition, a total of 51,857 hardship claims totaling $3,041,831 were received by DHS-IME during fiscal years 2010 through 2012, which accounted for 40% of total premiums billed of $7,554,817.

Vaudt reported several instances of non-compliance with IowaCare administrative rules established by DHS for determining IowaCare eligibility and the premiums to be assessed to participants. Certain documentation essential for determining eligibility and premium assessment was not available, including applications and premium agreements. In addition, some premium assessments listed on the DHS Notice of Decision (NOD) were not sufficiently supported by available case file information. For example, there are differences in the household size listed on the application compared to the household size used by DHS on the NOD and a lack of sufficient supporting documentation for countable income used by DHS on the NOD.

Vaudt recommended the State Legislature (Legislature), DHS and DHS-IME give careful consideration to the State's ability to maintain IowaCare if unrestricted participant growth continues. In addition, Vaudt recommended the Legislature, DHS and DHS-IME review the current premium structure and the impact of hardship exemptions on IowaCare revenue and determine if the ability for participants to claim unlimited hardship exemptions conflicts with the intent of IowaCare.

Vaudt also recommended DHS implement procedures to ensure eligibility determinations and premium assessments are supported by sufficient documentation. DHS should not process applications which contain discrepancies or have incomplete, unclear or missing information without first resolving such issues. Also, DHS should consistently verify self-reported application information to improve the accuracy of application data and reduce the risk of approving an individual who does not meet eligibility requirements.

A copy of the report is available for review in the Office of Auditor of State and on the Auditor of State's web site at http://auditor.iowa.gov/specials/1260-4010-B0P1.pdf.

# # #

A REVIEW OF THE IOWACARE PROGRAM
ADMINISTERED BY THE
IOWA MEDICAID ENTERPRISE
WITHIN THE
DEPARTMENT OF HUMAN SERVICES

JULY 1, 2009 THROUGH JUNE 30, 2012

Table of Contents

		Page
Auditor's Transmittal Letter		3-4
Introduction		5-10
Objectives, Scope and Methodology		10-11
Administration		11-19
Purpose and Goals		19-21
Future Plans and Other Compliance Issues		21
Findings and Recommendations		22-27
Schedule:	Schedule	
Health Care Transformation Account: Revenues by Source and Expenditures by Appropriation Unit	1	29
Staff		30
Appendices:	Appendix	
Map of the IowaCare Provider Service Areas	A	32
Copy of an IowaCare Billing Statement	B	33

OFFICE OF AUDITOR OF STATE
STATE OF IOWA

David A. Vaudt, CPA
Auditor of State

State Capitol Building
Des Moines, Iowa 50319-0004

Telephone (515) 281-5834 Facsimile (515) 242-6134

To the Governor, Members of the General Assembly, the
Director of the Department of Human Services and the
Director of the Iowa Medicaid Enterprise:

In conjunction with our audit of the financial statements of the State of Iowa and in accordance with Chapters 11 and 249J of the *Code of Iowa*, we have conducted a review of the IowaCare program (IowaCare) administered by the Iowa Medicaid Enterprise, a division of the Department of Human Services (DHS-IME). Our review was conducted to determine if IowaCare was administered in compliance with applicable laws, rules and guidelines and also to determine if IowaCare is meeting the program purpose and goals. In conducting our review, we performed the following procedures for the period July 1, 2009 through June 30, 2012:

(1) Interviewed personnel from DHS administration and DHS-IME to gain an understanding of IowaCare and evaluated internal controls over the application process, eligibility determination, premium assessments, provider claims and quality control.

(2) Reviewed applicable laws, rules and guidelines to identify the compliance requirements.

(3) Evaluated program integrity procedures performed by DHS-IME to determine if they are sufficient to ensure payments to IowaCare network providers and non-participating providers are appropriate and overpayments made to providers are recovered when applicable.

(4) Evaluated quality control review procedures performed by DHS to ensure appropriate IowaCare eligibility determinations are made by DHS.

(5) Analyzed revenue and expenditure activity recorded in the IowaCare, Health Care Transformation and Non-participating Provider Accounts to identify trends related to the statewide IowaCare expansion.

(6) Examined selected IowaCare case files to determine compliance with eligibility requirements, to determine if premiums were properly assessed and to determine if enrollment was canceled for non-payment of premiums due.

(7) Obtained a list of health promotion partnerships to determine if the required number were established in compliance with the *Code*.

(8) Reviewed IowaCare provider agreements and analyzed statistical reports containing enrollment and premium data and other significant aspects of IowaCare to identify trends related to its statewide expansion.

(9) Reviewed quarterly and annual IowaCare reports to determine if the required reports were submitted to the Governor and the General Assembly in compliance with the *Code*.

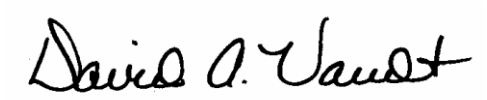
(10) Reviewed meeting minutes for the Medical Assistance Projections and Assessment Council to determine if they met at least annually, as required by the *Code*.

(11) Evaluated IowaCare to determine compliance with the purpose and goals established by the *Code* and the IowaCare waiver.

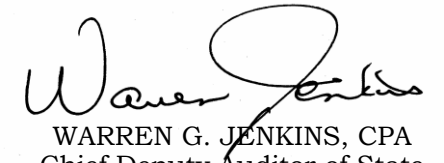
Based on these procedures, we have developed certain recommendations and other relevant information we believe should be considered by the Governor, the General Assembly, the Department of Human Services and the Iowa Medicaid Enterprise.

The procedures described above do not constitute an audit of financial statements conducted in accordance with U.S. generally accepted auditing standards. Had we performed additional procedures, or had we performed an audit of the Department of Human Services or the Iowa Medicaid Enterprise, other matters might have come to our attention that would have been reported to you.

We extend our appreciation to the personnel of the Department of Human Services and the Iowa Medicaid Enterprise for the courtesy, cooperation and assistance provided to us during this review.



DAVID A. VAUDT, CPA
Auditor of State



WARREN G. JENKINS, CPA
Chief Deputy Auditor of State

October 29, 2012

Introduction

Title XIX of the Social Security Act is the legal basis for Medicaid. Medicaid is a state administered program which provides medical assistance to families who meet certain eligibility criteria. As part of the Social Security Act, each state establishes its own guidelines regarding eligibility and services.

The State Legislature (Legislature) established the IowaCare Act, effective July 1, 2005, as part of an initiative to reform the State's Medicaid program. Included in the IowaCare Act was approval for creation of the IowaCare program (IowaCare). IowaCare was designed to replace the State's former indigent care program, known as State Papers, which was federally funded through a mechanism known as Intergovernmental Transfers (IGTs). The Federal Centers for Medicare and Medicaid Services (CMS) informed the State, effective July 1, 2005, the State would no longer be allowed to use IGTs to fund health care services. The inability to use IGTs positioned the State to lose approximately $65 million annually allotted to provide health care services to low-income Iowans who did not otherwise categorically qualify for Medicaid.

In accordance with section 1115(a) of the Social Security Act, IowaCare was authorized through a Medicaid waiver granted by CMS for the period July 1, 2005 through June 30, 2010, which was subsequently renewed and amended for the period July 1, 2010 through December 31, 2013. IowaCare is designed primarily to provide assistance to low-income uninsured Iowans between the ages of 19 and 64 who do not otherwise categorically qualify for Medicaid. The Iowa Medicaid Enterprise (IME), a division of the Department of Human Services (DHS), administers Medicaid and IowaCare. DHS administrative staff provides oversight and support, such as budgeting, fiscal and system services, while DHS-IME is primarily responsible for day-to-day IowaCare operations, such as processing provider claims and ensuring payments are made to approved IowaCare providers for reimbursement of services provided to approved IowaCare participants.

On February 25, 2011, subsequent to the enactment of the Federal Affordable Care Act on March 23, 2010, CMS issued a letter to all state Medicaid Directors regarding the states' maintenance of effort for all Medicaid programs. The letter specified, as a condition of receiving Federal Medicaid funding, states were to maintain Medicaid "eligibility standards, methodologies, and procedures" which were no more restrictive than those in effect on March 23, 2010. CMS also provided a "Questions and Answers" which specified the Affordable Care Act and the provisions of the maintenance of effort guidance apply to section 1115 waivers. Therefore, DHS and DHS-IME are held to the maintenance of effort requirement in effect for IowaCare at March 23, 2010 and cannot effect change to IowaCare until the program is renewed on January 1, 2014.

DHS and DHS-IME established the following objectives for IowaCare:

- improve access to and coordination of the most appropriate cost effective care through implementation of a medical home pilot,
- encourage provision of quality medical services to all participants,
- encourage quality, continuity and appropriate medical care,
- improve the health status of participants by improving access to a greater number of beneficiaries by adding additional network providers in underserved areas of the State and
- encourage individuals to stay healthy and seek preventive care through care coordination in the medical home pilot.

Current services covered by IowaCare for eligible individuals include:

- inpatient and outpatient hospital services,
- doctor and advanced registered nurse practitioner services,
- routine preventive medical examinations,
- obstetrical (OB) care, including newborns,
- limited prescription drug services,
- limited dental services,
- smoking cessation assistance,
- emergency services and
- care coordination.

Eligible individuals in the State include:

- individuals ages 19 through 64 with family incomes between 0% and 200% of the federal poverty level (FPL) who do not meet the eligibility requirements of the Medicaid State Plan or any other Medicaid demonstration project, except the Medicaid Family Planning demonstration project (Medicaid expansion population),
- parents with family income between 0% and 200% of the FPL whose income is considered in determining the eligibility of children found eligible under either Title XIX (Medicaid) or Title XXI (KidCare), who themselves are not otherwise eligible for the Medicaid expansion population,
- pregnant women who are not otherwise eligible under the Medicaid State Plan who have family income at or below 300% of the FPL, have incurred medical expenses for all family members which reduce available family income to below 200% of the FPL and who have resources in excess of the Medicaid State Plan limits for OB/newborn services and
- chronic condition participants, including patients enrolled in the former State Papers program in fiscal year 2005, who have ongoing chronic conditions and have income greater than 200% of the FPL.

IowaCare was amended, effective November 1, 2011, to create an uncompensated care pool. As a result, DHS-IME established IowaCare Safety Net Care Pools (I-SNCPs) allowing reimbursement of expenditures incurred by hospitals, clinics or other providers for uncompensated medical care costs for medical services provided to eligible participants. The following I-SNCPs were established to defray the following costs:

- Non-Covered Services – Broadlawns Medical Center (BMC) provides non-covered services to IowaCare participants. Payable services are limited to optometric services, podiatric services, durable medical equipment (DME) and pharmacy services.
- Care Coordination – IowaCare participating providers offer services necessary to ensure a positive outcome for the participant after an inpatient hospitalization. Payable services are limited to DME, in-home health care and rehabilitation and therapy services.
- Laboratory and Radiology Services – Federally Qualified Health Centers (FQHCs) participating in IowaCare who do not have the necessary laboratory and radiology equipment on site provide referrals to participants. Each participating FQHC identifies up to 4 laboratories and 4 radiology sites to which IowaCare participants will be referred.

Provider Network and Benefits

The IowaCare provider network has changed significantly from inception through June 30, 2012. The following paragraphs summarize the expansion of IowaCare during fiscal years 2010 through 2012.

Effective July 1, 2009, the State's 4 Mental Health Institutions (MHIs) located in Cherokee, Clarinda, Independence and Mt. Pleasant were no longer provided with funding from IowaCare. According to DHS-IME officials, CMS has a long-standing view state operated MHIs should not receive Medicaid funding. As a result, only 2 providers, BMC and the University of Iowa Hospitals and Clinics (UIHC), participated in IowaCare during the period July 1, 2009 through September 30, 2010.

Beginning October 1, 2010, the IowaCare provider network was gradually revised and expanded statewide by implementing a regional primary provider network in different regions of the State. In addition, CMS authorized DHS-IME to add FQHCs to the provider network to serve as a medical home, or provider, for participants. A medical home provides comprehensive primary care facilitating partnerships between individual patients, their personal providers and the patient's family, if appropriate.

Table 1 summarizes the expansion of the IowaCare provider network from 4 providers as of October 1, 2010 to 8 providers as of December 1, 2011.

Table 1

Effective Date	Number of Providers	Provider Names	Provider Locations
10/01/10	4	• Broadlawns Medical Center	Des Moines
		• University of Iowa Hospitals and Clinics	Iowa City
		• Peoples Community Health Clinic	Waterloo
		• Siouxland Community Health Center	Sioux City
07/01/11	3	• Community Health Center	Fort Dodge
		• Crescent Community Health Center	Dubuque
		• Primary Health Care	Marshalltown
12/01/11	1	• Council Bluffs Community Health Center	Council Bluffs

Appendix A includes a copy of the IowaCare provider service area map as of January 1, 2012. As illustrated by the **Appendix**, participants in all counties are assigned to 1 of the 8 providers, including the 6 FQHCs. In addition to its service area, BMC and UIHC also provide hospital services to participants located in the 5 western and 3 eastern provider service areas, respectively, when services are not available from the participants' primary provider. UIHC is also the statewide network provider of specialized consultative health care, usually for inpatients and referrals from a network provider, including advanced medical investigation and treatment which are highly specialized and not widely accessible.

Participants

Table 2 lists the number of IowaCare participants at June 30 for fiscal years 2006 through 2012 according to reports generated from the statistical reporting tool available on DHS-IME's website.

Table 2

Population Type	Participants as of June 30,						
	2006	2007	2008	2009	2010	2011	2012
Expansion	17,932	17,784	23,698	31,913	38,434	49,203	60,664
OB/newborn	16	13	12	14	10	9	-
Chronic condition	94	84	66	59	52	44	39
Total enrolled	18,042	17,881	23,776	31,986	38,496	49,256	60,703
Year-to-year change							
Total enrolled	-	(161)	5,895	8,210	6,510	10,760	11,447
Percentage	-	(1)%	33%	35%	20%	28%	23%

As illustrated by the **Table**, total enrollment in IowaCare has steadily increased since inception. Officials of DHS originally estimated approximately 14,000 Iowans would be served by IowaCare. However, total participants have increased from 18,042 at June 30, 2006 to 60,703 at June 30, 2012, an increase of 42,661, or 237%. See **Finding A**.

Program Funding

IowaCare is funded through a combination of federal funds, state appropriations and property tax collections from Polk County residents. In addition to the base appropriation, the Legislature has authorized supplemental appropriations up to specified amounts each year if sufficient federal funds are received. The supplemental appropriations are non-reverting and any unused portion can be carried forward for use in subsequent fiscal years. The state appropriations and Polk County property tax are deposited to the IowaCare Account and are eligible to receive federal matching dollars.

IowaCare Account – Monies deposited to the IowaCare Account are used for payment of medical services provided by network providers to participants. **Table 3** lists the sources of revenue credited to the IowaCare Account and the expenditure of those funds as recorded in the State's accounting system by fiscal year for fiscal years 2010 through 2012.

Table 3

Description	Fiscal Year Ended June 30,		
	2010	2011	2012
Revenues			
Federal support	$ 78,257,978	89,779,499	97,299,957
Polk County property tax	38,000,000	38,000,000	40,000,000
State General Fund appropriation	-	4,601,848	4,480,304
Interest	83,874	45,760	33,694
Total revenues	116,341,852	132,427,107	141,813,955
Expenditures			
BMC	48,297,168	46,270,453	54,376,458
UIHC	61,996,210	68,521,411	75,233,833
UIHC physicians	-	14,000,000	16,277,753
Other Medicaid	24,134	21,112	1,824,372
Regional provider network	-	876,747	2,092,248
Care coordination pool	-	-	706,945
Laboratory test and radiology pool	-	-	411,729
Total expenditures	110,317,512	129,689,723	150,923,338
Revenues over (under) expenditures	$ 6,024,340	2,737,384	(9,109,383)

As illustrated by the **Table**, revenues increased approximately $25.5 million, or 22%, while expenditures increased approximately $40.6 million, or 37%, from fiscal year 2010 to fiscal year 2012. Total revenues exceeded total expenditures in fiscal years 2010 and 2011 while total expenditures exceeded total revenues by approximately $9.1 million in fiscal year 2012. Because IowaCare is a waiver program within Medicaid, CMS and DHS consider IowaCare funds to be a portion of total Medicaid funding. As a result, fiscal staff at DHS allocates other Medicaid funding to IowaCare as necessary to cover costs at year-end.

Increases in both total revenues and total expenditures were expected, primarily due to increased funding received to expand coverage statewide and implement additional services, such as obstetrical care provided to pregnant women, emergency services, care coordination and laboratory and radiology services.

As previously reported in the IowaCare report issued in 2010, total revenues and expenditures recorded in the IowaCare Account in fiscal year 2006 were approximately $97 million. In fiscal year 2012, total revenues recorded in the IowaCare Account were approximately $141.8 million, an increase of approximately $44.8 million, and total expenditures were approximately $150.9 million, an increase of approximately $53.9 million. See **Finding A**.

Health Care Transformation Account (HCTA) – The HCTA was established to account for the initiatives, design, development and administration of IowaCare. IowaCare participants are assessed a monthly premium based on the household's monthly income as a percentage of the FPL. The State share of premiums received is deposited to the HCTA and used in accordance with the requirements specified in section 249J.23(3) of the *Code of Iowa*. The remainder of the premiums received is deposited to other Medicaid programs. **Table 4** lists the sources of revenue credited to the HCTA and the related expenditures for fiscal years 2010 through 2012.

Table 4

Description	Fiscal Year Ended June 30, 2010	2011	2012
Revenues			
Federal support	$ 2,026,209	1,947,892	2,142,535
Interest	195,956	75,594	59,144
Premiums	509,414	315,589	324,877
Total revenues	2,731,579	2,339,075	2,526,556
Total expenditures	4,003,934	4,573,726	8,129,043
Revenues under expenditures	$ (1,272,355)	(2,234,651)	(5,602,487)

As illustrated by the **Table**, total revenues decreased approximately $205,000, or 8%, from fiscal year 2010 to fiscal year 2012 while total expenditures more than doubled, from approximately $4 million to approximately $8.1 million. In addition, total revenues under expenditures increased approximately $4.3 million, or 340%, from fiscal year 2010 to fiscal year 2012. As previously stated, because IowaCare is a waiver program within Medicaid, CMS and DHS-IME consider IowaCare funds to be a portion of total Medicaid funding. As a result, fiscal staff at DHS allocates other Medicaid funding to IowaCare as necessary to cover costs at year-end. **Schedule 1** summarizes revenues by source and expenditures by appropriation unit for the HCTA for fiscal years 2010 through 2012.

Non-participating Provider Reimbursement (NPR) Account – The NPR Account was authorized by the Legislature, effective July 1, 2009, but was not established until July 1, 2010. Beginning with fiscal year 2011, it was used to account for emergency services provided to participants by providers outside the IowaCare provider network. **Table 5** lists the sources of revenue credited to the NPR Account and the related expenditures for fiscal years 2011 and 2012.

Table 5

Description	Fiscal Year Ended June 30, 2011	2012
Revenues		
Federal support	$ 513,073	1,401,337
State appropriations	594,000	776,200
Total revenues	1,107,073	2,177,537
Total expenditures	834,223	2,309,070
Revenues over (under) expenditures	$ 272,850	(131,533)

As illustrated by the **Table**, total expenditures exceeded total revenues by $131,533 in fiscal year 2012. Total reimbursements to non-participating providers for emergency services increased approximately $1.5 million over the total reimbursed during fiscal year 2011.

Objectives, Scope and Methodology

Objectives

Our review was conducted in conjunction with our audit of the financial statements of the State of Iowa and in accordance with Chapters 11 and 249J of the *Code of Iowa* to determine if IowaCare was administered in compliance with applicable laws, rules and guidelines and to determine if IowaCare is meeting the program purpose and goals.

Scope and Methodology

To gain an understanding of IowaCare, we:

- reviewed significant laws, rules, policies, legislative documentation, data and reports available from DHS-IME and documents filed with the U.S. Department of Health and Human Services (HHS) and
- interviewed representatives of DHS and DHS-IME responsible for administration of the Medicaid program, including IowaCare.

To determine if IowaCare achieved favorable results for program goals, we:

- reviewed various documents to determine the goals of the initiative,
- reviewed quarterly and annual IowaCare reports prepared and published by DHS-IME,
- obtained and reviewed a copy of the external evaluation of IowaCare conducted by the University of Iowa Public Policy Center (UIPPC) in fiscal year 2011 and
- reviewed statistical reports available on DHS-IME's website for participant data.

To determine if IowaCare was administered in compliance with the *Code of Iowa*, we:

- reviewed Chapter 249J of the *Code*,
- reviewed Chapter 441-92 of the Iowa Administrative Code (IAC),
- interviewed individuals directly responsible for administration of IowaCare,
- selected 60 case files to review applications and other documentation for compliance with established eligibility criteria,
- selected 15 case files to recalculate the premium assessed,
- selected 5 participants to determine if benefits had been canceled for non-payment of premiums and the amount owed referred to collections,
- obtained, summarized and analyzed financial data from the State's accounting system and the DHS-IME Medicaid Management Information System (MMIS) and
- reviewed available minutes for the Medical Assistance Projections and Assessment Council (MAPAC) established pursuant to section 249J.20 of the *Code*.

We randomly selected 60 case files from the IowaCare participant database maintained by DHS-IME, 20 from each fiscal year from 2010 through 2012, for eligibility testing. To test premiums assessed, we judgmentally selected 15 participants from the 60 case files selected, 5 from each fiscal year.

Administration

In accordance with section 249J.4 of the *Code*, objectives of the IowaCare Act include:

- proposing a variety of initiatives to increase the efficiency, quality and effectiveness of the health care system,
- increasing access to appropriate health care,
- providing incentives to consumers to engage in responsible health care utilization and personal health care management,
- rewarding providers based on quality of care and improved service delivery and
- encouraging the utilization of information technology, to the greatest extent possible, to reduce fragmentation and increase coordination of care and quality outcomes.

The IowaCare Act encompasses many components of Medicaid health reform for the State of Iowa. This report focuses primarily on IowaCare services delivered to participants.

Participant Eligibility and Application Process

Individuals must apply to receive services under IowaCare and meet the eligibility criteria established pursuant to section 249J.5 of the *Code*. As previously stated, the majority of IowaCare participants are included as part of the Medicaid expansion population and must:

- have documented citizenship,
- be between the ages of 19 and 64 or a newborn child of a qualifying participant,

- have countable income (80% of gross earned income) less than 200% of the FPL,
- not have access to group health insurance, not be able to afford group health insurance, have exclusions for pre-existing conditions or need services which are not covered by other available health insurance coverage and
- not have been disqualified from Medicaid for reasons other than income, extra resources or categorical eligibility.

Individuals serving a prison sentence and those who have been placed on a work release program are considered inmates and not eligible for IowaCare. However, individuals placed on probation or parole who are living in a halfway house are not considered inmates and may be eligible for IowaCare, as long as they meet the other eligibility criteria.

An individual with access to group health insurance is usually not eligible for IowaCare. However, an individual with such access may apply for IowaCare if the individual states any of the following conditions exist:

- the coverage is unaffordable,
- exclusions for pre-existing conditions apply,
- needed services are not covered by the available plan,
- the benefits limits under the available plan have been reached or
- the available plan includes only catastrophic health care coverage.

Because the IowaCare provider network expanded statewide, all eligible participants may receive additional services, including OB/newborn, care coordination, radiology and laboratory and emergency services. Providers may be reimbursed for these additional services when participants meet the additional eligibility requirements and funding is available from DHS-IME during the fiscal year in which services are needed.

OB/Newborn – In addition to the Medicaid expansion population eligibility criteria, applicants seeking obstetrical care provided to pregnant women must have countable income at or below 300% of the FPL and qualifying medical expenses which lower countable income to 200% of the FPL or below. Eligible participants residing in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott or Washington counties seeking OB/newborn services must receive the services from UIHC. Eligible participants residing in all other counties of the State may receive OB/newborn services from any IowaCare provider. Covered OB/newborn services include obstetric services provided in an inpatient hospital, outpatient hospital or physician's office, including coverage of newborn children born to eligible participants.

IowaCare Safety Net Care Pools (I-SNCPs) – Individuals seeking care coordination or laboratory and radiology services under IowaCare must be eligible participants and services are provided only to the extent of available funding.

Emergency Services – Subject to the level of funding appropriated by the Legislature, IowaCare participants may receive emergency services from hospitals other than BMC and UIHC if the following requirements are met:

- it is not medically possible to postpone provision of services and transfer the individual to a primary network provider or the individual cannot be transferred to a primary IowaCare network provider due to a lack of inpatient capacity,
- the individual is enrolled in IowaCare at the time treatment is provided and

- the hospital is located in Iowa. Covered services must include emergency services, as designated by the State, and medically necessary treatment to the point the individual is medically stable and able to be transferred to a primary network provider. The State is not required to reimburse costs for emergency services provided outside the primary IowaCare provider network if expenditures for such services exceed the available funding.

Application Process – According to IAC section 441-92.3, IowaCare participants must renew their application every 12 months based on the enrollment date. Applications are available at local DHS offices, BMC, UIHC, participating FQHCs and online at DHS' website and must be submitted to the local DHS office for processing. Applications are approved based on the information self-reported by the applicant, including income, number of household members, age and access to group health insurance. A face-to-face interview is not required for approval and DHS personnel do not independently verify the information reported on a routine basis, but may request verification information when believed necessary.

According to the DHS representatives we spoke with, DHS caseworkers have the option to request additional information from the applicant based on their judgment. If verification is requested, the applicant must be notified in writing and has 5 days to respond. Applications must be approved by DHS-IME within 3 working days, unless application information is being verified or the applicant's eligibility for services under other Medicaid programs is being reviewed. Once eligibility has been determined, approval is granted for a 12-month period. Any changes to income or household size are not reviewed until the applicant's renewal period. See **Finding B**.

Review of Eligibility – Representatives of DHS-IME provided a copy of the IowaCare participant database to select case files to review for compliance with eligibility requirements. To determine if the database was complete, we compared the number of participants listed in the database to the enrollment statistics available on DHS-IME's website. Based on this comparison, we determined the number of participants included in the database was reasonably complete.

We randomly selected 60 case files from the database of IowaCare participants to determine compliance with the eligibility requirements. The 60 case files are maintained in the Electronic Case File (ECF) system of DHS, which includes IowaCare applications, verification documentation, as applicable, notices of decision (NODs), significant communication letters and other relevant documentation. If information was not available in the ECF system, we requested and reviewed hard copy case files. According to the DHS IowaCare Employee Manual, DHS caseworkers are required to retain copies of the applications and all relevant documentation supporting the eligibility determinations of the applicants. We identified several instances of non-compliance. See **Finding C**. The results of our testing are summarized below:

- 5 case files contained applications which were not processed timely. According to section 441-92.4 of the IAC, applications are to be approved or denied within 3 working days, unless certain conditions exist.

- 5 case files did not contain an application, including 4 for fiscal year 2010 and 1 for fiscal year 2011. For 2 of the 5 case files identified, hard copy files were not available from DHS. Therefore, we were unable to determine if the hard copy application had been received and retained. For the remaining hard copy case files, neither the electronic nor hard copy application could be located. DHS personnel confirmed the 5 case files do not contain an application.

  Because the 5 applications could not be located, we were unable to determine if:

  - the 5 participants were between the ages of 19 and 64 and should have signed an IowaCare premium agreement.

  - 3 of the 5 participants were U.S. citizens. According to the DHS representatives we spoke with, DHS caseworkers are required to verify citizenship status for all IowaCare applicants.
  - the family income of 1 participant was at or below 200% of the FPL.
- 2 case files contained the application, but certain information, such as household income, was not included on the application.

In addition, DHS-IME frequently performs automated matching of the data in MMIS with data contained in other systems, such as the Department of Corrections' (DOC) system and other DHS systems to identify potential issues which may impact the eligibility of IowaCare participants, such as whether the participants were serving a prison sentence or were in a work release program and whether the participants had access to group health insurance. Also, prior to October 1, 2010, section 441-92.2(5) of the IAC specified participants were to pay incurred and unpaid premiums from a previous enrollment before new enrollment can be established. According to a representative of DHS-IME, MMIS did not allow caseworkers to approve a participant with an outstanding premium balance. If a caseworker attempted to approve a participant with an outstanding balance, MMIS would generate a fatal worker action notice and the participant would not be approved.

Automated system checks are also performed by MMIS to determine if the participants received benefits under other State programs or were eligible under other Medicaid coverage. According to sections 441-75.3 and 441-92.4(2) of the IAC, participants must take all necessary steps to apply for and accept any income or other resources for which they may qualify, such as pensions, retirement benefits or workers' compensation insurance, and must be evaluated for eligibility under another coverage group within Medicaid. If the participant is eligible for another coverage group within Medicaid, the IowaCare application is considered to be an application for that group. However, no supporting documentation is maintained to demonstrate the automated system checks are performed and working properly.

We also determined DHS does not consistently verify self-reported application information, such as income and household size. Of the 60 case files selected, 54 did not contain supporting documentation for the household composition listed on the application. DHS and DHS-IME perform quality control reviews and other program integrity procedures to verify the eligibility of IowaCare participants. However, the reviews and matching procedures implemented by DHS and DHS-IME are performed after the applicants have been approved and are receiving services. In addition, the results of the procedures performed are not consistently documented. See **Finding D**. Also see the "Monitoring and Reporting" section of this report for further discussion of quality control procedures.

Financial Responsibility

Premiums are assessed to IowaCare participants based on income as a percentage of the FPL. Participants who are unable to pay their monthly premium, in part or entirely, may request a hardship exemption by submitting a written statement declaring the monthly premium would be a financial hardship.

As of January 26, 2012, the federal poverty guidelines established by HHS specify the FPL for a household of 1 is $11,170. Each additional household member increases this level by $3,960. During fiscal years 2010 through 2012, the FPL and the administrative rules contained in IAC 441-92.7 were revised multiple times, resulting in changes to the IowaCare premium levels. **Table 6** summarizes the range of monthly premiums assessed based on the FPL for the corresponding household size during fiscal years 2010 through 2012.

Table 6

Effective Date	Number of Participants	FPL Range	Premium Range
07/01/09	1 or more	up to 110%	$0
	1 or more	110% to 200%	$45 to $85
10/01/10	1 or more	up to 150%	$0
	1	150% to 200%	$47 to $60
	2 or more	150% to 200%	$63 to $80
06/01/11	1 or more	up to 150%	$0
	1	150% to 200%	$50 to $63
	2 or more	150% to 200%	$68 to $85
04/01/12	1 or more	up to 150%	$0
	1	150% to 200%	$51 to $65
	2 or more	150% to 200%	$69 to $86

Table 7 summarizes premiums billed, total premiums paid, hardship claims and premiums due as of June 30 for fiscal years 2010 through 2012. Because only the State share of premiums paid is recorded in the HCTA, the total premiums paid included in **Table 7** will not agree with the premium revenue included in **Table 4**. **Table 7** also lists the year-to-date enrollment and the average monthly premium billed per participant.

Table 7

Description	Fiscal Year Ended June 30, 2010	2011	2012
Premiums billed	$ 3,828,703	2,199,098	1,527,016
Less:			
Premiums paid	1,748,840	1,024,756	810,226
Hardship claims	1,645,736	893,342	502,753
Total premiums due	$ 434,127	281,000	214,037
Year-to-date enrollment	57,235	70,677	86,802
Average monthly premium billed per participant	$ 67	31	18

As illustrated by the **Table**, total premiums due is calculated by deducting premiums paid and hardship claims from premiums billed. The number of year-to-date participants reflects total participants receiving services under IowaCare during the fiscal year. The **Table** also illustrates the impact of the average monthly premium billed per participant on total premiums billed. Although the year-to-date enrollment has steadily increased, the reduction in the average monthly premium billed per participant resulted in a decrease of approximately $2.3 million, or 60%, in premiums billed from fiscal year 2010 to fiscal year 2012.

In addition, although the premium ranges increased from October 1, 2010 to April 1, 2012, as illustrated by **Table 6**, the average monthly premium billed per participant decreased $49, from $67 to $18, from fiscal year 2010 to fiscal year 2012, as illustrated by **Table 7**. This decrease is primarily due to the adjusted FPL percentages at which no premium is assessed to IowaCare participants. As illustrated by **Table 6**, the FPL percentage increased from 110% to 150%, effective October 1, 2010.

In addition, the number of participants who were not billed a premium increased dramatically, from 34,323 in fiscal year 2010 to 59,082 in fiscal year 2012, an increase of 24,759, or 72%. At the same time, the number of hardship claims decreased dramatically, from 28,745 in fiscal year 2010 to 8,641 in fiscal year 2012, a decrease of 20,104, or 70%. However, from fiscal year 2010 to fiscal year 2012, 51,857 premium

hardships totaling more than $3 million, or 40% of premiums billed, were granted by DHS-IME. As of June 30, 2012, 59,082 participants, or 97% of the total number of participants, are not required to pay a premium.

Section 441-92.7 of the IAC specifies the monthly premium will not increase for a 12-month eligibility period, regardless of increases in income or changes in household size. However, the monthly premium may be reduced for a decrease in income or an increase in household size within the 12-month eligibility period. See **Finding B**.

We reviewed 15 of the 60 case files selected for eligibility testing to determine if premiums were properly assessed and identified 2 instances of non-compliance. For 2 case files, the applications did not include income information. While the premium calculation summarized on the NOD was correct based on data listed by DHS, we were unable to verify the calculation. See **Finding E**.

Participants assessed a premium are required to pay the premium for 4 months, regardless of continued enrollment. After 4 months, participants must pay the premium for each month they remain eligible to receive services under IowaCare. DHS sends monthly IowaCare Billing Statements to participants detailing the premium due and the corresponding due date. **Appendix B** includes a copy of an IowaCare Billing Statement.

Failure to make the premium payment results in cancellation of benefits, effective 60 days after the premium due date. In addition, DHS-IME refers the unpaid premiums for collection. Through October 1, 2010, section 441-92.2(5) of the IAC specified participants were to pay incurred and unpaid premiums from a previous enrollment before new enrollment could be established. However, effective October 1, 2010, this section was modified to state an application for IowaCare shall not be affected by any unpaid premiums from any previous enrollment in accordance with changes in federal requirements. We selected 5 participants with past due premiums to determine if DHS-IME properly canceled benefits and referred the amount owed to collection and did not identify any concerns. As a result, we did not expand our testing.

Participants who are unable to pay their monthly premium, in part or entirely, may request a hardship exemption by submitting a written statement to DHS-IME declaring the monthly premium would be a financial hardship. As illustrated by **Appendix B**, the IowaCare Billing Statement includes a preprinted hardship exemption request which must be signed by the participant. This signed statement is then returned in lieu of making the monthly premium payment.

If the written statement is received no later than 5 working days after the premium due date, the monthly premium is forgiven and benefits remain intact. Participants must submit the written statement each month to continue receiving the hardship exemption. There is no limit on the number of hardship exemptions which may be submitted by a participant. According to DHS-IME personnel, all hardship requests are granted. However, section 441-92.7(3) specifies the participant will not receive a hardship exemption if the participant misrepresented the household's circumstances. According to a representative of DHS-IME, no verification procedures are performed prior to granting the hardship request. See **Finding F**.

Provider Payments

The Legislature appropriates funding from the IowaCare Account to DHS for the provision of services to participants by BMC, UIHC and the 6 FQHCs. Funds are also appropriated for the provision of emergency services from hospitals other than BMC and UIHC. Funds administered by DHS-IME are assigned by service area within MMIS in order to account for the expenditures separately.

The annual appropriation provided for BMC and UIHC is divided into 12 equal monthly payments, or prospective interim payments (PIPs). In addition to receiving the monthly

PIPs, BMC and UIHC submit claims for IowaCare services rendered in the same manner as other Medicaid claims. However, these claims do not generate a payment. Rather, the claims are valued using the standard Medicaid reimbursement rates and accumulated in MMIS.

At the end of each fiscal year, a cost settlement process is performed, during which the PIPs and accumulated claims are reconciled to determine the amount of federal financial participation to be claimed for IowaCare. When the PIPs received by BMC and UIHC exceed the valuation of the IowaCare claims at the end of the fiscal year, the difference is applied as an enhanced payment for the provider's graduate medical education costs (GMEs), up to a set established maximum, if applicable. If additional funds remain, a disproportionate share hospital (DSH) payment is made, which is a supplement used to provide patient care and services not covered by IowaCare. If federal financial participation is not available because both GME and DSH qualifying funds have reached the maximum, any remaining costs will be paid from available State funds.

Each network provider is assigned a unique provider number which is required to be included on claims submitted for IowaCare participants. For those providers which are enrolled to provide multiple types of services (i.e., hospital and physician), a unique provider number is assigned for each type of service. Each provider is also assigned to the appropriate service area in MMIS. Providers are required to submit claims to DHS-IME for services rendered to IowaCare participants in the same manner as other Medicaid claims, except under their unique IowaCare provider number. Claims are processed through the normal adjudication cycle within MMIS and are either paid or denied. Paid claims are tracked against the appropriate service area in MMIS.

The only exception to the regular claims process is payments for emergency services and care coordination. These providers are considered out-of-network and are not assigned a unique provider number. They submit all claims under their regular Medicaid provider number.

Table 8 summarizes total paid claims recorded in MMIS for each network provider, as of June 30, for fiscal years 2010 through 2012. As illustrated by **Table 3**, the payments for medical services provided by BMC and UIHC are recorded separately in the IowaCare Account in the State's accounting system. However, payments to the FQHCs are combined and recorded under regional provider network and/or laboratory test and radiology pool. We were able to materially reconcile the total paid claims recorded in MMIS, illustrated by **Table 8**, with the combined regional provider network and laboratory test and radiology pool expenditures recorded in the IowaCare Account, illustrated by **Table 3**.

Table 8

Network Provider	Fiscal Year ended June 30, 2010	2011	2012
BMC	$ 48,297,168	46,270,453	54,376,458
UIHC	61,996,210	82,521,411	91,511,586
Community Health Center of Fort Dodge	-	-	415,359
Council Bluffs Community Health Center	-	-	190,498
Crescent Community Health Center	-	-	276,588
Peoples Community Health Clinic	-	680,649	690,215
Primary Health Care	-	-	222,347
Siouxland Community Health Center	-	196,417	709,721
Total	$ 110,293,378	129,668,930	148,392,772

Monitoring and Reporting

DHS administration is responsible for financial oversight, such as budgeting, recording and processing payments and ensuring IowaCare financial activity is accurately recorded in the State's accounting system. DHS-IME is primarily responsible for IowaCare administration and monitoring within the Medicaid program and preparing reports submitted to CMS, the Governor and the Legislature summarizing IowaCare financial activity, trends and results, as required by CMS and Chapter 249J of the *Code*. In addition, the UIPPC completes an evaluation of IowaCare for DHS-IME each fiscal year.

Medicaid Eligibility Quality Control (MEQC) System – The Code of Federal Regulations, 42 CFR 431.800, establishes the state plan requirement for the MEQC program designed to reduce erroneous expenditures by monitoring eligibility determinations. The Medicaid compliance supplement allows DHS-IME to operate pilot projects focusing on special studies, targeted reviews or other activities designed to ensure program integrity or improve program administration. DHS-IME obtained approval from CMS to perform the MEQC IowaCare pilot project for the period January 1, 2010 through December 31, 2010. The pilot project consisted of verifying applicants' self-reported applications to ensure appropriate Medicaid and IowaCare eligibility determinations were being made by DHS.

During fiscal year 2010, as part of the MEQC, a limited number of quality control reviews were performed by DHS, which did not produce any negative results. DHS increased quality control reviews for IowaCare completed during fiscal years 2011 and 2012 and plans to continue similar quality control coverage of IowaCare. As part of the federal compliance audit completed each fiscal year, the financial auditors within our Office test selected quality control reviews performed by DHS quality control staff to evaluate the results identified. The resulting audit reports issued for fiscal years 2010 and 2011 included a finding and recommendation regarding the lack of supporting documentation in the DHS files to show coverage was canceled due to lack of cooperation and failure to complete an insurance questionnaire by the participant. The fiscal year 2012 federal compliance audit is not yet complete.

Program Integrity (PI) – PI routinely inspects claims submitted to DHS-IME by Medicaid and IowaCare providers to assure Medicaid payments, including IowaCare, are for covered services. CMS requires all states ensure proper and efficient administration of the Medicaid program. PI responsibilities include claims analysis and provider profiling of health care delivery patterns.

To fulfill these responsibilities, PI reviews data for unusual billing practices, which are often identified by comparing providers to their peer groups and analyzing the services billed. Potential issues identified by this analysis are further reviewed by PI through a clinical record review process. A payment recovery or adjustment is made if PI determines an overpayment by Medicaid or IowaCare has occurred.

In addition, PI periodically performs data matching of Medicaid and IowaCare records with DOC records, Social Security Administration records and death records and birth certificates maintained by Vital Records within the Department of Public Health. PI also performs data mining queries on MMIS on a weekly, monthly or quarterly basis to identify potential areas for recoupment and/or further review. For example, PI queries all claim types to identify participants with a date of death prior to the date of service or claims paid to deceased providers (i.e., a physician). In addition, PI routinely performs comprehensive procedures to review or investigate provider activity, such as completing on-site reviews, medical records reviews, explanation of medical benefits reviews and recoupment of overpayments made to providers.

Based on a review of the PI procedures performed for fiscal years 2011 and 2012, the provider reviews completed by PI included extensive coverage of providers claiming

reimbursement for services provided to IowaCare participants. Specifically, PI reviewed and investigated IowaCare providers for:

- compliance with relevant general and specialty-specific billing and coding guidelines and medical necessity and
- potential discrepancies in claims submitted for reimbursement, such as:
  - duplicate billing,
  - diagnoses not supportive of the services provided,
  - services provided after the participant's date of death,
  - unusual or inappropriate quantity of services provided,
  - inappropriate diagnosis and procedure code use,
  - dates of service prior to provider enrollment date,
  - inappropriate number of units billed,
  - billing services outside of the normal provider specialty and
  - unusual or unexplained billing irregularities.

PI summarizes and tracks provider overpayments and pursues recoupment, as necessary. PI also refers investigations to the Medicaid Fraud Control Unit within the Department of Inspections and Appeals, the HHS Office of Inspector General and the U.S. District Attorney Offices when additional investigation of provider fraud is needed and prosecution may be pursued. PI maintains documentation of all provider reviews completed, including, but not limited to, records demonstrating identification, follow-up and resolution of overpayments made to providers, recoupment tracking spreadsheets and an overall PI performance summary for each fiscal year. According to the performance summary for fiscal years 2011 and 2012, approximately $6 million and $10.6 million, respectively, were identified for recoupment for the Medicaid program, including IowaCare.

Purpose and Goals

The purpose of IowaCare is summarized in section 249J.4 of the *Code*. According to the "Special Terms and Conditions Medical Home Requirements" in the current IowaCare waiver approved by CMS, the goals established for IowaCare include:

- increasing IowaCare participant satisfaction with health care,
- improving statewide access of IowaCare participants to quality health care,
- reducing duplication of services,
- enhancing communication among providers, families and community partners,
- improving the quality of health care to IowaCare members through the patient-centered medical home model and
- promoting and supporting a plan for meaningful use of health information exchange (HIE) in accordance with requirements.

To address each goal, we reviewed various IowaCare reports completed by DHS-IME, the UIPPC evaluations and other relevant IowaCare documentation, as follows:

- Increased Satisfaction – According to the UIPPC evaluation of IowaCare for fiscal year 2011, there is mixed satisfaction with health care services reported by the IowaCare participants surveyed compared to previous years. Implementation of the medical home model has alleviated or reduced concerns with difficulty in finding a

personal doctor and receiving emergency care. Approximately 71% of participants receiving care from multiple doctors also received care coordination assistance to a certain extent. Most participants received care coordination services from BMC or UIHC, but these services were also provided by other network providers. Of those receiving assistance, approximately 85% were either very satisfied or satisfied with the assistance they received. The most common concern was an inability to make appointments with multiple doctors on the same day.

- Improved Statewide Access – From fiscal year 2010 to fiscal year 2012, statewide access to IowaCare was gradually improved as a result of expanding the provider network. As previously stated, the IowaCare provider network consists of 8 providers, including BMC, UIHC and 6 FQHCs located in different regions of the State. As illustrated by **Appendix A**, the 8 IowaCare providers serve counties as assigned and approved under the current IowaCare waiver. As a result of the expanded provider network, IowaCare participation has also increased. The UIPPC evaluation of IowaCare also reported access has increased dramatically and enrollment numbers have steadily increased since the inception of IowaCare. The report states, "The vast majority (88%) of participants used IowaCare for most or all of their health care. Over half (56%) had used IowaCare coverage to get care, tests or treatment in the previous 6 months."

- Reduced Duplication of Services – DHS-IME increased efforts to reduce duplicate services billed by increasing quality control reviews of eligibility determinations and placing increased emphasis on program integrity reviews of providers. DHS-IME also implemented automated reviews within MMIS to identify duplicate services billed. In addition, PI performs extensive reviews, analyses, data mining, investigations and other procedures to reduce billing of duplicate services, incorrect coding by providers and billing for services not provided.

- Enhanced Communication – DHS-IME implemented the electronic exchange of information throughout the provider network and increased the available information on the DHS-IME website regarding IowaCare within Medicaid.

- Improved Quality of Health Care – The UIPPC completes a comprehensive evaluation of the details of IowaCare, including measuring the extent of improvement to the quality of health care provided to IowaCare participants through the patient-centered medical home model. DHS-IME has expanded the provider network throughout the State and has added services provided under IowaCare since inception of the program. For example, effective November 1, 2011, IowaCare coverage expanded to include emergency services, which may be provided by non-network providers in addition to network providers. In addition, DHS-IME implemented care coordination, electronic HIE and radiology and laboratory services throughout the provider network.

  The October 2011 UIPPC evaluation report includes detailed information obtained through surveys completed by select participants. Participants were asked to rate the following for IowaCare health care services received on a scale of 0 to 10 with 10 being the best:

  - all health care received – 42% of participants rated all IowaCare health care received a 9 or 10, 31% rated health care received a 7 or 8 and the remaining 27% rated the care received a 6 or less.
  - their personal doctor – 52% of participants rated their personal doctor at BMC or UIHC a 9 or 10, 28% gave a rating of 7 or 8 and the remaining 20% rated their personal doctor a 6 or less.
  - time spent with their doctor – 80% of participants rated their personal doctor as always, or usually, spending enough time, 14% responded their doctor sometimes spends enough time and the remaining 6% responded their doctor never spends enough time.

- their specialist doctor – 54% of participants rated the specialist visited at BMC or UIHC a 9 or 10, 29% gave a rating of 7 or 8 and the remaining 17% rated the specialist a 6 or less.
- the hospital overall – 52% of participants rated the hospital a 9 or 10, 27% gave a rating of 7 or 8 and the remaining 21% rated the hospital a 6 or less.

- Promoted and Supported HIE – DHS-IME implemented a Health Information Technology (HIT) group consisting of representatives of DHS-IME and the 8 providers. The purpose of the HIT group is to address HIT needs for every aspect of IowaCare, including changes to DHS-IME software for billing, sending notices to participants and electronic connections between providers to easily transfer information. The HIT group meets as needed and provides guidance to the IowaCare Steering Committee as HIT issues arise. The Steering Committee members include the DHS-IME Medicaid Director, representatives of the 8 providers and a representative of the Iowa Primary Care Association. The Steering Committee meets as needed to discuss new and ongoing issues with the goals of improving the program, resolving issues as they arise and planning for future changes.

  In addition, DHS-IME requires network providers to report the status of their Electronic Health Records (EHRs) on a quarterly basis, as required by the IowaCare waiver. EHRs are promoted by HHS to increase coordination of patient care, reduce medical errors, eliminate duplicate screenings and tests and increase the patient's engagement in the care received. As of July 2012, all 8 IowaCare participating providers have fully functioning EHRs.

Based on the October 2011 UIPPC evaluation report and other IowaCare reports reviewed, DHS-IME has made reasonable progress toward meeting the goals of IowaCare.

Future Plans and Other Compliance Issues

Future Plans – The IowaCare waiver renewal was approved by CMS for the period July 1, 2005 through December 31, 2013. However, according to DHS-IME staff, possible extension of IowaCare will not be known until after the next Legislative session in 2013.

Other Compliance – We reviewed Chapter 249J of the *Code* to determine if DHS-IME is administering IowaCare in accordance with established requirements. As a result, we identified an area of non-compliance. According to section 249J.20 of the *Code*, the MAPAC shall meet at least annually to make cost projections, review quarterly reports on initiatives for the IowaCare Act, review financial statements and assure the expansion population is managed within funding limitations. We determined the MAPAC did not meet at least annually.

Only 2 meetings were held on May 13, 2010 and June 23, 2010 during fiscal years 2010 through 2012. During these 2 meetings, the MAPAC reviewed reports on initiatives of the IowaCare Act and made additional recommendations to DHS-IME for health care reform. However, based on a review of meeting minutes, the MAPAC did not review the consensus projection of expenditures during either of the 2 meetings held during 2010. See **Finding G**.

Findings and Recommendations

We reviewed IowaCare in conjunction with our audit of the financial statements of the State of Iowa and in accordance with Chapters 11 and 249J of the *Code of Iowa* to determine if IowaCare was administered in compliance with applicable laws, rules and guidelines and to determine if IowaCare is meeting program goals and expectations. As a result, we identified certain findings and recommendations regarding IowaCare which should be considered by the Governor, the Legislature, DHS and DHS-IME. Our findings and recommendations are summarized below.

FINDING A – IowaCare Growth

Officials of DHS-IME originally estimated approximately 14,000 Iowans would be served by IowaCare. As a result of IowaCare expansion statewide, including increased availability of emergency services, radiology and laboratory services, care coordination and other services, IowaCare enrollment has grown dramatically since inception. From June 30, 2006 to June 30, 2012, enrollment increased 42,661, or 237%, from 18,042 to 60,703. During the fiscal year ended June 30, 2012, 86,802 participants received services under IowaCare.

DHS requested and received approval from the Legislature for additional IowaCare funding each fiscal year. Total revenues recorded in the IowaCare Account increased from approximately $97 million in fiscal year 2006 to approximately $141.8 million in fiscal year 2012, an increase of approximately $44.8 million.

Recommendation – The Legislature, DHS and DHS-IME should give careful consideration to the State's ability to maintain IowaCare if unrestricted participant growth continues.

Response – IowaCare has been available statewide to any eligible member since it began in 2005. Limited benefits for IowaCare members have also not changed from implementation of the program in 2005. Legislatively approved funding includes funding pools for emergency services, radiology and laboratory services, and care coordination. These were appropriated to assist providers with uncompensated care already being provided.

However, IowaCare members were limited to only one of two IowaCare network providers, Broadlawns Medical Center (Polk County residents only) and the University of Iowa Hospitals and Clinics (non-Polk County residents). On January 1, 2012, the IowaCare provider network was expanded to improve access and quality of care. The IowaCare provider network now includes six Federally Qualified Health Centers in addition to the University of Iowa and Broadlawns Medical Center. As access to care closer to home improved, more individuals applied for IowaCare benefits.

The Department agrees with the recommendation that careful consideration must be given to the State's ability to maintain IowaCare if unrestricted participant growth continues and has submitted a waiver amendment to CMS to set an enrollment cap for the IowaCare program. The department is currently awaiting CMS approval for this amendment request.

Conclusion – Response accepted.

FINDING B – Annual Certification

According to section 441-92.3 of the Iowa Administrative Code (IAC), once eligibility has been determined, approval is granted for a 12-month period, regardless of changes to income or household size. In addition, section 441-92.7 of the IAC specifies premiums will not be increased despite household income increases or household size decreases. However, premiums can be decreased if household income decreases or household size increases.

Recommendation – Although currently unable to effect changes to eligibility standards, methodologies and procedures as a result of federal requirements, if IowaCare is renewed effective January 1, 2014, the Legislature, DHS and DHS-IME should consider a modification to the IAC to allow for premium increases during the year as is currently allowed for premium decreases. Flexibility to increase premiums should be established to allow DHS-IME to make any necessary adjustments which may be needed to help preserve IowaCare if future budget cuts are made at the federal and/or state level.

Response – The current IowaCare 1115 waiver expires on December 31, 2013. Legislative authority and CMS approval of a 1115 waiver will be required to continue the program beyond that date. Due to Maintenance of Effort (MOE) requirements under the Affordable Care Act (ACA), the Department cannot make any changes in eligibility criteria at this time. If the program continues beyond the current expiration date, the Department will consider this recommendation and others in the program redesign.

Conclusion – Response accepted.

FINDING C – Eligibility Compliance

We identified several instances of incomplete case files and/or non-compliance with the eligibility requirements included in Chapter 441-92 of the IAC for the 60 case files tested, as follows:

- 5 case files contained applications which were not processed timely. According to section 441-92.4 of the IAC, applications are to be approved or denied within 3 working days, unless certain conditions exist.
- 5 case files did not contain an application. Because the applications could not be located, we were unable to determine if:
    - the 5 participants were between the ages of 19 and 64 and should have signed an IowaCare premium agreement,
    - 3 of the 5 were U.S. citizens and
    - the family income of 1 participant was at or below 200% of the FPL.
- 2 case files contained an incomplete application. As a result, we were unable to determine eligibility.

In addition, although automated system checks are performed to verify certain eligibility requirements, such as whether the participants were serving a prison sentence, were on a work release program, had access to group health insurance, received benefits under other State programs or had been screened for eligibility under another coverage group within Medicaid, no supporting documentation is maintained to demonstrate the automated system checks are performed and working properly.

Also, prior to October 1, 2010, section 441-92.2(5) of the IAC specified participants were to pay incurred and unpaid premiums from a previous enrollment before new enrollment can be established. According to a representative of DHS-IME, MMIS automatically verified whether an applicant had an outstanding balance and would not allow a caseworker to approve an applicant with such a balance. However, no supporting documentation was maintained to demonstrate the automated system check was performed and worked properly. Effective October 1, 2010, this section was modified to state an application for IowaCare shall not be affected by any unpaid premiums from any previous enrollment in accordance with changes to the federal requirements.

Recommendation – Although currently unable to effect changes to eligibility standards, methodologies and procedures as a result of federal requirements, if IowaCare is renewed, effective January 1, 2014, DHS should implement procedures to ensure timely processing of applications and compliance with all eligibility requirements prior to

approving individuals applying for IowaCare coverage. Also, DHS should consistently maintain complete case files and maintain all documentation in the ECF system and hard copy case files, including, but not limited to:

- applications, changes in coverage, premium agreements and related documentation, such as communication letters to participants,
- eligibility determination and any adjustments made to IowaCare coverage for participants identified as an inmate of a correctional facility, in a work release program or on parole,
- determination of the FPL,
- NODs,
- documentation of receipt of benefits under other State programs and
- any other relevant documentation and verification information used by DHS caseworkers to determine if an applicant is eligible to receive services.

Response – Section 441-92.3 of the IAC state, in part, "An application is considered filed on the date an identifiable application is received and date-stamped in any place of filing specified in subrule 76.1(2)." For 2 of the cases cited for untimely processing, the worker processed the application within three days of receipt of the application, resulting in a timely approval or denial. For the remaining 3 cases cited in error, the supervisors and administrators for these cases have been notified of the error and will review with the workers the requirement to process applications timely.

For the 5 case files cited for a lack of documentation, the Department has been moving towards electronic case file storage. Historical documentation, such as applications, will be more readily available to reviewers in the future. To avoid inappropriate coverage, staff complete an annual re-determination of eligibility. Any changes to the makeup of a case, as reported by the client, would also result in a re-determination of eligibility. While the original application may not be available for review, the individuals are considered eligible through the re-determination process.

Policy states, in part, "an application must have a legible name, address, and signature to be considered a valid application." When an application is presented with no other information, the worker will assist the applicant in obtaining information in order to make a determination. Prior to approval, and regardless of whether or not the information is listed on the application, the worker verifies citizenship, identity, alien status (if applicable), eligibility for Medicare, outstanding medical bills, and earned income. For the 2 case files cited for incomplete information, the application contained the required information as stated in the policy. A review of the cases in the Department's computer systems confirmed the subsequent eligibility determination was accurate.

The Department will review the automated system checks to determine they are working as intended.

Conclusion – Response acknowledged. For 2 of the 5 cases identified for untimely processing, based on a review of supporting documentation maintained in the case file, we were unable to determine whether the delay was a result of the applicant or DHS. In addition, for the 2 case files cited as incomplete, we realize additional procedures are performed by the worker prior to approval if an application only contains a name, address and signature. However, there was no documentation of the additional procedures performed included in the case file.

FINDING D – Verification of Application Information

According to section 441-92.4 of the IAC, IowaCare applicants are not required to provide verification of income, household size, disability, social security number, age, group health insurance and/or pregnancy unless the verification is specifically requested in writing. DHS does not consistently verify information self-reported by applicants, such as income and household size. Of the 60 case files selected, 54 did not contain supporting documentation for the household composition listed on the application. DHS and DHS-IME have implemented procedures to review application and claim information, such as whether participants were serving a prison sentence, had been placed on a work release program or had access to group health insurance. However, the procedures are performed subsequent to an applicant receiving approval and services under IowaCare.

Recommendation – Although currently unable to effect changes to eligibility standards, methodologies and procedures as a result of federal requirements, if IowaCare is renewed effective January 1, 2014, DHS should consider amending the IAC to require verification of self-reported application information prior to application approval to improve the accuracy of application data and reduce the risk of approving individuals who are not eligible for services. In addition, DHS should consistently maintain documentation of verification procedures performed and the related results in the ECF system and hard copy case files, including, but not limited to:

- verification of whether individuals applying for IowaCare have access to group health insurance,
- verification of income and other resources, including supporting documentation obtained to verify income, resources and household size listed on the IowaCare application and information identified through performance of additional procedures, such as comparing MMIS data against other system data,
- verification individuals applying are between the ages of 19 and 64 and
- verification of receipt of other benefits and coverage under other Medicaid programs.

Response – According to section 441-92.4 of the IAC, IowaCare applicants are not required to provide verification of certain types of information prior to approval of IowaCare. The 54 cases cited are not in error as they are properly following the IAC. After the application process, several items are verified through automated data matches with other state and federal systems, including, but not limited to, group health insurance, income, age, and eligibility for other programs. There are no resource requirements for IowaCare; therefore, no verification of resources is needed.

The current IowaCare 1115 waiver expires on December 31, 2013. Legislative authority and CMS approval of an 1115 waiver will be required to continue the program beyond that date. Due to Maintenance of Effort (MOE) requirements under the Affordable Care Act (ACA), the Department cannot make any changes in eligibility criteria at this time. If the program continues beyond the current expiration date, the Department will consider this recommendation and others in the program redesign.

Conclusion – Response acknowledged. The 54 cases identified are not considered to be in non-compliance with the IAC. Rather, they are an illustration of the type of information which is not currently verified or supported. In addition, as previously stated, although DHS has implemented procedures to review application and claim information, the procedures are performed subsequent to an applicant receiving approval and services under IowaCare.

FINDING E – Premiums

Of the 15 case files for which premiums were tested, we identified 2 case files in which the applications did not include income information. Of the 2 case files identified, 1 contained an incomplete application as identified in **Finding C**. While the premium calculation summarized on the NOD was correct based on the data listed by DHS, we were unable to verify the calculation.

Recommendation – DHS should implement procedures to ensure premiums assessed are supported by sufficient documentation to demonstrate the calculation of countable income. In addition, DHS should not process applications which contain discrepancies or have incomplete, unclear or missing information without first inquiring and resolving such issues. Case files should contain sufficient documentation to support the premium assessed, including explanations for any difference between the application information and the information used to determine the premium.

Response – Policy states, in part, "an application must have a legible name, address, and signature to be considered a valid application." Policy also states, "if the information in the "Income" and "Resource" areas is left blank, the Department will take that to mean the applicant does not have any money or resources." For the 2 case files cited as errors, the Department has re-reviewed the case files and the data screens reporting income of the clients. The Department's re-review resulted in the same determination as the original review, the income and resource section of the application were appropriately left blank. Void of any income, there would be no premiums due on either case. The 2 case files cited are not in error.

The Department is in the process of developing a new eligibility system. The new system will verify the applicant's income with IRS records.

Conclusion – Response acknowledged. As stated in the finding, the premium calculation on the NOD was correct based on the data listed by DHS. However, sufficient supporting documentation was not available to allow verification of the calculation.

FINDING F – Premium Hardship Claims

Participants who are unable to pay their monthly premium, in part or entirely, may request a hardship exemption by submitting a written statement to DHS-IME declaring the monthly premium would be a financial hardship. If the written statement is received no later than 5 working days after the premium due date, the monthly premium is forgiven and benefits remain intact. Participants must submit the written statement each month to continue receiving the hardship exemption. There is no limit on the number of hardship exemptions which may be submitted by a participant and all hardship requests are granted. No verification procedures are performed prior to granting the hardship requests to determine if the request is valid.

Recommendation – Although currently unable to effect changes to eligibility standards, methodologies and procedures as a result of federal requirements, if IowaCare is renewed effective January 1, 2014, the Legislature, DHS and DHS-IME should review the effect of hardship exemptions on IowaCare revenue and the overall impact to IowaCare. Because a key component of the IowaCare waiver was shared financial responsibility for participants, the Legislature and DHS-IME should determine if the ability for participants to claim unlimited hardship exemptions conflicts with the intent of IowaCare. In addition, DHS-IME should ensure financial status and other on-going eligibility factors of participants is verified and considered prior to granting hardship exemptions.

Response – The current IowaCare 1115 waiver expires on December 31, 2013. Legislative authority and CMS approval of a 1115 waiver will be required to continue the program beyond that date. Due to Maintenance of Effort (MOE) requirements under the

Affordable Care Act (ACA), the Department cannot make any changes in eligibility criteria at this time. If the program continues beyond the current expiration date, the Department will consider this recommendation and others in the program redesign.

Conclusion – Response accepted.

FINDING G – Medical Assistance Projections and Assessment Council (MAPAC)

According to section 249J.20 of the *Code of Iowa*, the MAPAC shall meet at least annually to make cost projections, review quarterly reports on initiatives for the IowaCare Act, review financial statements and ensure the expansion population is managed within funding limitations.

The MAPAC did not meet at least annually during fiscal years 2010 through 2012. The only meetings held during that period were May 13, 2010, and June 23, 2010. During the 2 meetings held, the MAPAC reviewed reports on initiatives of the IowaCare Act and made additional recommendations to DHS-IME for health care reform. However, based on a review of meeting minutes, the MAPAC did not review the consensus projection of expenditures during either of the 2 meetings held during 2010.

Recommendation – The MAPAC should meet at least annually to perform its specified functions, as required by the *Code of Iowa.* Otherwise, DHS officials should work with the Legislature to repeal or amend the applicable *Code* section.

Response – The MAPAC is a legislatively mandated committee for which the Department has no oversight authority. The Department can make recommendations to appeal or amend the applicable code section, but ultimately the decision to do so will require legislative authority.

Conclusion – Response accepted.

Schedule

A Review of the IowaCare Program

Health Care Transformation Account
Revenues by Source and Expenditures by Appropriation Unit
Fiscal Years 2010 through 2012

Description	Fiscal Year Ended June 30, 2010	2011	2012
Revenues			
Federal support	$ 2,026,209	1,947,892	2,142,535
Interest	195,956	75,594	59,144
Premiums	509,414	315,589	324,877
Total revenues	2,731,579	2,339,075	2,526,556
Expenditures			
Health care transformation	43,269	52,501	55,974
Medical information hotline	236,126	257,592	257,592
Medicaid smoking cessation	551,975	429,557	423,079
Audits, performance evaluations and studies	88,565	157,482	176,632
IowaCare administrative costs	339,687	1,415,388	768,198
Dental home for children	1,832,722	1,967,025	1,980,671
Tuition assistance for individuals serving people with disabilities	13,019	11,950	6,779
BMC administration	265,833	290,000	290,000
Medical assistance	300,000	-	1,956,245
Medical exams - expansion population	160,725	(7,769)	-
Seamless computer system - Department on Aging	172,013	-	-
Medical contracts	-	-	1,464,779
Uniform cost report	-	-	150,000
Health Care Access Council	-	-	134,214
Transfer to Public Health for e-health	-	-	363,987
Transfer to Public Health for medical home	-	-	100,893
Total expenditures	4,003,934	4,573,726	8,129,043
Revenues under expenditures	$ (1,272,355)	(2,234,651)	(5,602,487)

A Review of the IowaCare Program Administered by
the Department of Human Services

Staff

This review was conducted by:

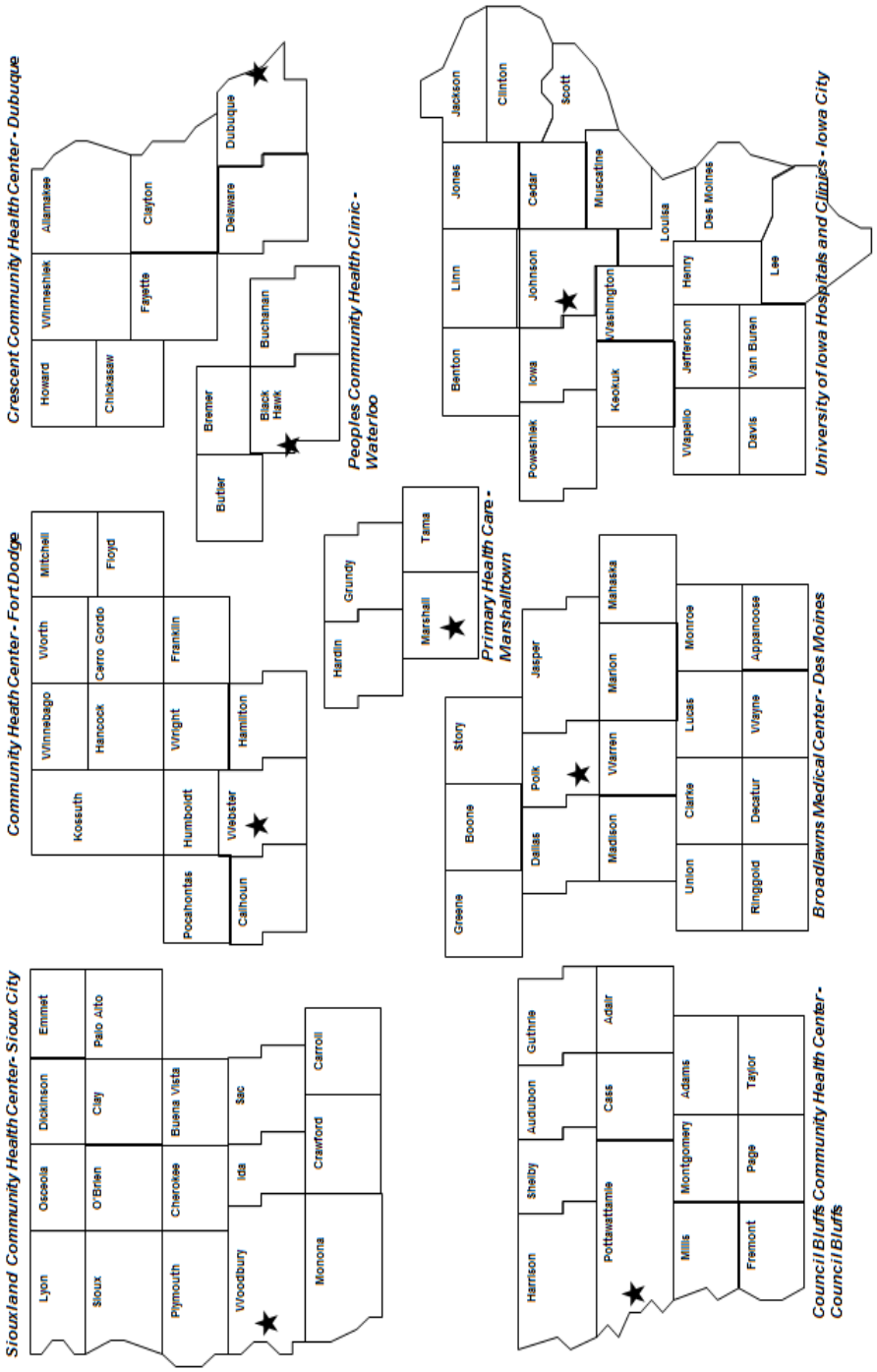
Annette K. Campbell, CPA, Director
Jennifer Campbell, CPA, Manager
Mark C. Moklestad, CPA, Senior Auditor
Kayley R. Alexander, Assistant Auditor
Stephen J. Hoffman, Assistant Auditor
Philip A. Rethwisch, Assistant Auditor

Tamera S. Kusian, CPA
Deputy Auditor of State

Appendices

A Review of the IowaCare Program

Map of the IowaCare Provider Service Areas



A Review of the IowaCare Program

Copy of an IowaCare Billing Statement

S2001

Iowa Department of Human Services

IowaCare Billing Statement

Date

KEEP THIS INFORMATION FOR YOUR RECORDS

Dear

You must pay a premium to continue to get coverage under the IowaCare program. This is a bill that tells you how much your premium is and when it is due.

Make your check or money order payable to the IowaCare program. Please do not send cash. Send your payment in the enclosed envelope to: Iowa Medicaid Enterprise, PO Box 10391 Des Moines, IA 50306-0391

If you don't pay your premium by the due date, you may no longer be covered by IowaCare.

Payments made on your account are listed below. If payments were listed on another statement, those payments will not show up here.

Month	Premium Amount Due	Due Date	Payment Received	Payment Applied	Date Applied	Refund Amount

Total Owed:

Total Credit:

You may pay in advance. Your payments will be used to pay old unpaid premiums before being used for current or future premiums.

If you have any questions, please call your local county DHS office. Report changes directly to your DHS county worker.

MAIL THIS STATEMENT IN THE ENCLOSED ENVELOPE ← DETACH AT PERFORATION →

Due Date: Amount Due:

If you are unable to pay, you must sign in the box below. This signed statement must be received at the above address. If not received by the above due date you will still owe the premium for this month. Because I have spent or will spend my monthly income on food, housing, utilities, transportation or other health care, I am not able to pay my IowaCare premium for this month. So, I am not able to send the amount on this billing statement.

DETACH AT PERFORATION

Signature

Date