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NEWS RELEASE

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FOR RELEASE April 9, 2010

Auditor of State David A. Vaudt today released a report on the IowaCare program administered by the Iowa Medicaid Enterprise, a division of the Department of Human Services (DHS-IME), for the period July 1, 2005 through June 30, 2009. 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 the IowaCare program was administered in compliance with applicable laws, rules and guidelines and also to determine if the IowaCare program has met program goals and expectations.

The IowaCare program was established in accordance with Section 1115(a) of the Social Security Act through a Medicaid waiver authority granted by the Centers for Medicaid and Medicare Services for the period July 1, 2005 through June 30, 2010. The IowaCare program was designed to replace $66 million lost to the State of Iowa due to termination of a federal funding mechanism called intergovernmental transfers (IGT's). IGT's provided the State with federal funds which were used to administer the State's former indigent care program, State Papers. The creation of the IowaCare program allowed the State to use Polk County tax dollars allotted for Broadlawns Medical Center to obtain matching federal funds to offer limited Medicaid benefits to low-income uninsured Iowans between the ages of 19 and 64 who do not categorically qualify for Medicaid.

Section 249J of the *Code of Iowa* established the IowaCare program to provide limited Medicaid benefits to enrollees when services were obtained from a participating provider in the IowaCare provider network, which consists of Broadlawns Medical Center, the University of Iowa Hospitals and Clinics and the State's 4 Mental Health Institutions. Initial enrollment projections estimated IowaCare would serve approximately 14,000 enrollees. As of June 30, 2009, 31,986 individuals were enrolled in the IowaCare program and 45,213 unique enrollees were served during the fiscal year ended June 30, 2009.

Eligibility for IowaCare is primarily based on household income as a percentage of the federal poverty threshold established annually by the U.S. Department of Health and Human Services. Individuals wishing to enroll in IowaCare must submit an application to DHS for approval. Application information is self-declared, meaning it is not required to be verified by DHS.

Vaudt reported several requirements of Section 249J of the *Code of Iowa* were not complied with by DHS-IME. In addition, Vaudt recommended several items be considered by DHS-IME should the program waiver be renewed. These items for consideration include verification of application information, expansion of the provider network, reimbursement for physician services provided to IowaCare enrollees seeking treatment at the University of Iowa Hospitals and Clinics and review of the program premium structure and hardship exemptions.

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/index.html.

# # #

A REVIEW OF THE
IOWACARE PROGRAM
ADMINISTERED BY THE
DEPARTMENT OF HUMAN SERVICES

JULY 1, 2005 THROUGH JUNE 30, 2009

0860-4010-B0P2

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

In conjunction with our audit of the financial statements of the State of Iowa and in accordance with Chapter 11 of the *Code of Iowa*, we have conducted a review of the IowaCare Program administered by the Iowa Medicaid Enterprise, a division of the Department of Human Services (DHS-IME). We reviewed the performance targets established by DHS-IME to determine if IowaCare program objectives were achieved. In conducting our review, we performed the following procedures for the period July 1, 2005 through June 30, 2009:

(1) Interviewed personnel from DHS-IME to gain an understanding of the IowaCare program.

(2) Reviewed applicable laws, rules and guidelines.

(3) Contacted officials from Broadlawns Medical Center (BMC) and the University of Iowa Hospitals and Clinics (UIHC) to obtain data about provider administration of the IowaCare program.

(4) Review activity recorded in the IowaCare fund and the account for HealthCare Transformation.

(5) Reviewed results of an enrollee survey conducted by the University of Iowa Public Policy Department and compared the results of the survey to performance measures outlined by DHS-IME for the IowaCare program.

(6) Determined if monitoring and quality control procedures were in place for the IowaCare program.

(7) Reviewed annual IowaCare reports.

(8) Reviewed statistical reports for the IowaCare program available on DHS-IME's website for data about enrollment, premiums and other significant aspects of the IowaCare program.

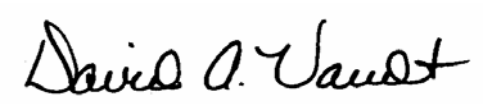
(9) Examined 35 IowaCare case files to determine if all eligibility requirements were complied with and premiums were properly assessed.

(10) Reviewed minutes for various committees and task forces established pursuant to the *Code of Iowa***.**

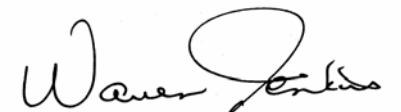
(11) Reviewed information available on the website for the Centers for Medicaid and Medicare Services to determine if other states operated programs similar to IowaCare.

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

We would like to acknowledge the assistance and many courtesies extended to us by the officials and personnel of the Department of Human Services throughout the engagement.



DAVID A. VAUDT, CPA
Auditor of State



WARREN G. JENKINS, CPA
Chief Deputy Auditor of State

January 14, 2010

Introduction

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

The 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. The IowaCare program 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 (IGT's). 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 IGT's to fund health care services. The inability to use IGT's 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.

The IowaCare program was established in accordance with section 1115(a) of the Social Security Act through a Medicaid waiver authority granted by CMS. According to the CMS website, "The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose, and distinct requirements." Section 1115 Research & Demonstration Projects "provide the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program."

The IowaCare Act addresses several components of health care reform to be implemented in various stages. A key component of the IowaCare Act was the implementation of the IowaCare program. The IowaCare program was approved for the period July 1, 2005 through June 30, 2010. Eligible participants are split into 3 population groups:

- expansion population (demo population 1),
- spend-down pregnant women (demo population 2) and
- seriously emotionally disabled children (demo population 3).

In addition, IowaCare allowed for benefits to be provided to individuals enrolled in the State Papers program during fiscal year 2005 who suffered from a chronic condition but did not qualify for IowaCare because their household income exceeded the IowaCare income eligibility threshold. However, benefits were limited to services and prescriptions necessary to treat the chronic condition. Eligible participants were required to enroll in IowaCare by June 30, 2006. This group was not included with the original waiver because the needs were not apparent until after program approval.

Table 1 lists the number of Iowans enrolled in IowaCare at June 30 for each year since inception of the program according to reports generated from a statistical reporting tool available on DHS-IME's website. Because the seriously emotionally disabled children group is treated and reported as a separate waiver, we have not included the group in the **Table**.

Table 1

Population Type	Fiscal Year Ended June 30, 2006	2007	2008	2009
Expansion	17,932	17,784	23,698	31,913
OB/Newborn	16	13	12	14
Chronic Condition	94	84	66	59
Total	18,042	17,881	23,776	31,986

The IowaCare program is funded through a combination of federal funds, state appropriations and property tax collections from Polk County residents. The state and local monies are deposited to the State's IowaCare account and are eligible to receive two-to-one federal matching dollars. Monies deposited to the IowaCare account are used for payment for medical services to members of the IowaCare provider network. **Table 2** lists the sources of revenue credited to the IowaCare account by fiscal year since inception of the program.

Table 2

Funding Source	Fiscal Year Ended June 30, 2006	2007	2008	2009
Federal Support	$ 61,715,340	63,606,451	69,237,244	76,040,227
Local Funds (Polk County)	34,000,000	34,000,000	34,000,000	38,000,000
Appropriation From the Health Care Transformation Account	1,327,364	5,672,637	5,000,000	-
State General Fund Appropriation	-	-	4,524,235	-
Interest	-	697,477	283,736	157,399
Total	$ 97,042,704	103,976,565	113,045,215	114,197,626

In addition, the Health Care Transformation Account was established to account for the initiatives, design, development and administration of IowaCare. **Table 3** lists the sources of deposits to the Health Care Transformation Account. The establishment of the Health Care Transformation Account was in accordance with House File 2347, 2006 legislative session, which required the State to provide $54,639,129 in the form of 2 one-time payments to UIHC. The payments included $20,216,039 to offset the cost of providing care to medical assistance patients and $34,423,090 to compensate UIHC for physician services provided to Medicaid patients. In turn, UIHC transferred the money back to the State, of which $19,350,061 was deposited to the General Fund for medical assistance and $35,289,068 was deposited to the Health Care Transformation Account to establish its beginning balance.

Table 3

Funding Source	Fiscal Year Ended June 30, 2006	2007	2008	2009
Establishment of Account	$ 35,289,068^	-	-	-
Federal Support	223,087	1,075,808	1,542,548	1,606,438
Interest	228,013	1,754,686	1,213,962	558,673
Premium Collections	358,250	456,141	911,248	881,217
Total	$ 36,098,418	3,286,635	3,667,758	3,046,328

^ - *State General Fund through UIHC.*

Premiums are assessed to IowaCare enrollees based on income as a percentage of the federal poverty threshold. Approximately 63% of the proceeds from premium collections are paid to the U.S. Department of Health and Human Services as an offset to the program. As illustrated by **Table 3**, premium collections declined in fiscal year 2009. Beginning July 1, 2008, the federal share of premiums were deposited to the General Fund rather than the Health Care Transformation Account. According to DHS staff, this was an accounting change to simplify the process of transferring the federal share.

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 the IowaCare program was administered in compliance with applicable laws, rules and guidelines and also to determine if the IowaCare program has met program goals and expectations.

Scope and Methodology

To gain an understanding of the IowaCare Act, we:

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

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

- reviewed various documents to determine the goals of the initiative,
- reviewed annual IowaCare reports prepared and published by DHS-IME,
- obtained and reviewed a copy of an external evaluation of the IowaCare program conducted by the University of Iowa Public Policy Department,
- reviewed statistical reports available on DHS-IME's website for participant data and
- contacted officials of the UIHC and BMC to obtain additional data about the administration of IowaCare at the provider level.

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

- reviewed Chapter 249J of the *Code of* Iowa,
- reviewed Chapter 441-92 of the Iowa Administrative Code,
- interviewed individuals responsible for administration of the Medicaid program by DHS-IME,
- obtained a sample of 35 case files to review applications for compliance with established eligibility criteria and calculation of premium assessment and
- reviewed available minutes for various committees and task forces established pursuant to the *Code of Iowa*.

Program Administration

IowaCare is administered by the Iowa Medicaid Enterprise, a division of the Iowa Department of Human Services (DHS-IME). In accordance with Chapter 249J.4 of the *Code of Iowa*, objectives of the IowaCare Act are to:

- propose a variety of initiatives to increase the efficiency, quality and effectiveness of the health care system,
- increase access to appropriate health care,
- provide incentives to consumers to engage in responsible health care utilization and personal health care management,
- reward providers based on quality of care and improved service delivery and
- encourage 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 program services delivered to enrollees.

Participant Eligibility and Application Process

As previously stated, the IowaCare program was designed to fill the gap for low-income uninsured Iowans between the ages of 19 and 64 who do not categorically qualify for Medicaid. To be eligible for IowaCare, applicants must meet eligibility criteria established pursuant to Section 249J.5 of the *Code of Iowa*. As previously stated, IowaCare was established in accordance with section 1115(a) of the Social Security Act through a Medicaid waiver authority granted by CMS for the period July 1, 2005 through June 30, 2010. Eligible participants are split into the following 3 population groups:

- expansion population (demo population 1),
- spend-down pregnant women (demo population 2) and
- seriously emotionally disabled children (demo population 3).

In addition, IowaCare allowed for benefits to be provided to individuals enrolled in the State Papers program during fiscal year 2005 who suffered from a chronic condition but did not qualify for IowaCare because their household income exceeded the IowaCare income eligibility threshold. However, benefits were limited to services and prescriptions necessary to treat the chronic condition. Eligible participants were required to enroll in IowaCare by June 30, 2006. This group was not included with the original waiver because the needs were not apparent until after program approval.

Expansion Population – The majority of IowaCare enrollees belong to the Medicaid expansion population. To be eligible for the IowaCare program, expansion population applicants must meet the following criteria:

- documented citizenship,
- between the ages of 19 and 64 or a newborn child of a qualifying participant,
- countable income less than 200% of the federal poverty level,

- do not have access to group health insurance, cannot afford group health insurance, exclusions for pre-existing conditions apply or the necessary services are not covered and
- must not have been disqualified from Medicaid for reasons other than income, extra resources or categorical eligibility.

Expansion population members are entitled to receive certain limited health care benefits when services are obtained from a participating provider in the IowaCare provider network. Some health services, such as an annual physical, may be procured from any Medicaid participating provider. The provider network consists of:

- Broadlawns Medical Center (BMC), Des Moines (available only to residents of Polk County),
- University of Iowa Hospitals and Clinics (UIHC), Iowa City and
- The State's 4 Mental Health Institutions (MHIs) in Cherokee, Independence, Mt. Pleasant and Clarinda.

Spend-down Pregnant Women Population – The spend-down pregnant women population must meet all the above criteria, but they may be eligible for services if their countable income is 300% of the federal poverty level and qualifying medical expenses bring income to 200% of the federal poverty level or below.

In addition, with the exception of Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott or Washington counties, participants of this population may receive obstetric and newborn services from any Medicaid provider. Women seeking services in the counties listed above must receive services from the UIHC.

Seriously Emotionally Disabled Children Population – The seriously emotionally disabled children population covers children from birth to age 18 who have serious emotional disabilities and who:

- would be eligible for State Plan services if they were in a medical institution,
- need home and community based services in order to remain in the community and
- have income at or below 300% of the SSI federal benefit or net family income at or below 250% of the federal poverty level.

Although the seriously emotionally disabled children population is included in the IowaCare waiver, it is operated as a home and community based service (HCBS) waiver program. HCBS waiver programs are designed to provide long-term care in a community-based setting to allow the individual to remain in the community. According to discussions with officials of DHS-IME, the group was included with the IowaCare waiver because the timing of the programs coincided. The request submitted to CMS to renew the IowaCare program includes a provision to move this group from the IowaCare waiver to a separate HCBS waiver. We did not perform procedures for the seriously emotionally disabled children population group.

Chronic Condition Population – As previously stated, the IowaCare Program allows for benefits to be provided to individuals with documented chronic conditions who participated in the State Papers Program but were over the income threshold for IowaCare eligibility. The chronic condition population includes patients enrolled in State Papers in fiscal year 2005 who also:

- have ongoing chronic conditions and
- have income greater than 200% of the federal poverty level.

Application Process – According to Section 441-92.3 of the Iowa Administrative Code, IowaCare enrollees must reapply annually. Applications are available at local DHS county offices, BMC, UIHC and online at DHS-IME's website. Applications are submitted to the local DHS office for processing and are approved based on the information reported by the applicant. A face-to-face interview is not required for approval.

Applications are self-declared, meaning information reported on the application, including income, number of household members, age or access to group health insurance, is not required to be verified. If verification is requested, the applicant must be notified in writing and has 5 days to respond. Applications must be approved within 3 working days; however, exceptions exist to allow DHS-IME staff time to verify application information or to determine if the applicant is eligible for Medicaid. Once eligibility has been determined, approval is granted for a 12 month period even if changes occur in income or household size. See **Findings A** and **D**.

According to the Director of IME, application information is not routinely verified to simplify the application process and expedite approval for those in need of health care services. In addition, DHS does not have financial resources to verify self-reported information for all applicants.

Review of Eligibility – Officials of DHS-IME provided us with a database of IowaCare enrollees to select IowaCare case files to review for compliance with eligibility requirements. To determine if the database was complete, we compared the number of enrollees listed in the database to IowaCare enrollment statistics available on DHS-IME's website. We determined the number of enrollees in the database materially agreed to statistical enrollment data available on DHS-IME's website.

In addition, we compared the database to a listing of IowaCare case files selected by DHS for review as part of a quality control pilot program. The quality control pilot program was implemented to determine if applicants were accurately reporting self-declared application information. DHS examined 399 IowaCare case files from November 1, 2005 through October 31, 2006. We were unable to locate 18 of the 399 DHS quality control case files on the database. We were unable to determine why the IowaCare cases provided on the quality control listing were not included in the database. See **Finding B**.

We selected 35 case files from the database to determine compliance with the eligibility requirements. The 35 case files contained a total of 75 applications. We identified several instances of non-compliance. See **Finding C**. The results of our testing are summarized below:

- 13 applications did not have a corresponding Notice of Decision in the case file to show the approval status or the amount of premium assessed, if approved.
- 8 applications were not accompanied by a signed premium agreement (required when an application other than the standard IowaCare application is submitted).
- 8 applications were not approved within 3 business days and a reason for the delay was not noted in the case file.
- 7 applications appeared questionable as to whether the applicant had access to an employer-sponsored health plan.
- 2 case files did not include proof of citizenship.

- 2 applications reported the applicant had access to employer-sponsored group health care. The application was approved, but the case file did not provide documentation stating the circumstances why the applicant was eligible for IowaCare.

- 1 application was approved for an applicant with outstanding premiums.

- 1 application was denied because the applicant's spouse had outstanding past-due premiums. We were unable to locate specific guidance to address this circumstance. However, because the applicant was applying as an individual, it appears the application was improperly denied.

- 1 application was not in the case file; however, the corresponding notice of decision showed the applicant was approved for IowaCare.

According to the Director of IME, a contributing factor to the incomplete or inadequately documented case files is the high case load managed by local DHS workers.

Participant Benefits

Expansion population members are entitled to receive certain limited health care benefits when services are obtained from a participating provider in the IowaCare provider network. However, some health services, such as an annual physical, may be procured from any Medicaid participating provider. The provider network consists of:

- BMC, Des Moines (available only to residents of Polk County),
- UIHC, Iowa City and
- The State's 4 MHIs.

In addition to the provider network, the spend-down pregnant women group may receive obstetric and newborn services from any Medicaid provider, with the exception of enrollees who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott or Washington counties. Women living in these counties seeking obstetric and newborn services must receive treatment at UIHC.

Based on our review of enrollee county residence, approximately 50% of enrollees live in Polk County, Johnson County (home of UIHC) and counties surrounding Johnson County. As a result, access to care can be difficult, specifically for enrollees who reside outside Polk County and do not live near Iowa City. The IowaCare Act was amended during the 2009 legislative session to allow non-participating provider reimbursement for the IowaCare program under certain circumstances, but funding was not provided for the additional reimbursements. As a result, DHS-IME has not taken action to implement changes resulting from the amendment. See **Finding E**.

Benefits include inpatient hospital procedures, outpatient hospital services, physician and registered nurse services, dental services, prescriptions administered during an in-patient stay and a 10-day supply of prescription medication to take home after hospital discharge. We were unable to locate a detailed listing of specific services and covered benefits.

IowaCare benefits may vary depending on the services offered by the provider because providers have the ability to choose the level of services provided. For example, dental care is specified as a benefit of IowaCare. However, UIHC provides only tooth extractions while BMC provides some limited restorative care. See **Finding E**.

Benefits are effective the later of the first day of the month of application or the first day of the month all eligibility requirements are met. In addition, retroactive benefits are allowed for a period of 30 days prior to the date of application if the enrollee received care from an IowaCare provider and would have been eligible for IowaCare at the time of service.

In addition to services covered by IowaCare, UIHC and BMC offer programs to assist with access to durable medical equipment and prescription medications. UIHC also provides free transportation by appointment to IowaCare participants who are unable to procure transportation to Iowa City. UIHC and BMC also provide assistance centers for IowaCare enrollees. The costs of these services are absorbed by the providers and are not reimbursed from the IowaCare account. The value of these additional benefits are discussed in the **Provider Payments** section of this report.

Financial Responsibility

Enrollees in IowaCare are assessed a monthly premium based on the household's monthly income as a percentage of the federal poverty level. The most recent federal poverty guidelines established by the U.S. Department of Health and Human Services on April 1, 2009 show the federal poverty level for a household of 1 is $10,830. Each additional household member increases the income threshold by $3,740.

From July 1, 2005 through June 30, 2007, enrollees with household income between 20 and 200% of the federal poverty level for household size were assessed a monthly premium ranging from $1.00 to $80.00. Enrollees with income between 0 and 20% of the federal poverty level were not assessed a premium. On July 1, 2007, premiums were eliminated for all enrollees with incomes of 100% or less of the federal poverty level. Current monthly premiums for enrollees with incomes greater than 100% of the federal poverty level range from $45.00 to $85.00.

Enrollees who are assessed a premium are required to pay the premium for 4 months, regardless of continued enrollment. After 4 months, enrollees must pay the premium for each month they remain enrolled in IowaCare. Failure to make the premium payment results in cancellation of benefits. In addition, enrollees who have benefits cancelled must pay any past-due premiums before they may be re-enrolled in IowaCare.

Enrollees who are unable to pay part or all of their monthly premium may declare a hardship exemption by submitting, in writing, the monthly premium would be a financial hardship. If the written statement is received by the premium due date, the monthly premium is forgiven and benefits remain intact. There is no limit on the number of hardship exemptions which may be submitted. All hardship requests are granted. See **Finding F**.

Based on our review of statistical data available on DHS-IME's website, we determined premiums totaling $10,202,342 were billed between July 1, 2005 and June 30, 2009. Of that amount, premiums collected totaled $4,749,598, or 46.5% of the billed amount. There were 94,127 monthly hardship exemptions granted, which accounted for an additional $4,136,554, or 40.5%, of the billed premiums. The remaining $1,316,190 of the billed premiums were uncollected as of June 30, 2009.

Premiums may be mailed to or paid in person at the DHS-IME office in Des Moines. Approximately 63% of the premiums collected are turned over to the U.S. Department of Health and Human Services because they are considered an offset to the program. The remainder of the premiums are deposited to the State's Health Care Transformation Account and are used in accordance with the requirements specified in section 249J.23(3) of the *Code of Iowa*.

Section 441-92.7 of the Iowa Administrative Code specifies the monthly premium amount will not be increased for a 12 month application period due to an increase in income or change in household size. However, the monthly premium may be reduced for a decrease in income or increase in household size. See **Finding A**.

As previously stated, we requested 35 case files to review for compliance with eligibility requirements. In addition, we reviewed the same case files to determine if premiums were properly assessed. Of the 35 case files we obtained, we identified 29 of 75 applications resulted in the assessment of a monthly premium. The results of our testing are summarized below. See **Finding G**.

- We could not recalculate assessed premiums for 4 of 29 applications because adequate documentation was not provided in the case file to determine the poverty threshold and household size used by DHS-IME case workers to determine the monthly premium.

- For 9 applications, there was a difference between the number of household members declared on the application and the number of household members used to assess the monthly premium. For 6 of the 9, we reconciled the application information to the household count used to determine the premium based on documentation available in the case file. However, we were unable to determine why the variance existed for the remaining 3 applications because the case file did not provide adequate documentation.

- For 12 applications, there was a difference between the income reported on the application and the income used to assess the monthly premium. Of the 12 applications, 4 did not provide adequate documentation to determine why the variance existed. Another 6 applications were modified as a result of verification of the applicant's income. Monthly income of $846.16 for 1 application was not used in the assessment of the premium. The remaining application variance was due to a child-support deduction for which the case-worker subtracted the allowed $50.00 exclusion directly from the income instead of reporting the full income and subtracting the allowable exclusion for child support income.

- 2 applications showed the applicant received child support but the premium assessment did not consider an allowed deduction of $50 monthly for child support.

- 1 premium was not properly calculated based on the federal poverty level.

Provider Payments

As previously stated, the IowaCare provider network consists of the UIHC, BMC and the State's MHIs. However, as part of the original waiver agreement, the MHIs were no longer provided with funding from IowaCare beginning July 1, 2009. According to DHS-IME officials, there is a long-standing view by CMS that state run MHIs should not receive Medicaid funding. The compromise reached between DHS-IME and CMS was to initially allow the payments but fully phase them out by June 30, 2009.

Providers are each granted an annual appropriation divided into 12 monthly payments called prospective interim payments (PIP). Providers receive the PIP amount monthly. In addition to receiving the PIP, providers submit claims for IowaCare services rendered using the same procedures applied to all other Medicaid claims. However, the claims do not generate a payment. The claims are priced according to the standard Medicaid reimbursement rates.

At the end of each fiscal year, a cost settlement process is completed. The claims submitted by each provider are totaled and compared to the annual PIP payment to determine the

amount of federal financial participation that can be claimed for the IowaCare program. When the annual PIP payment received by the provider exceeds the pricing 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 (GME), if claimed, up to a set maximum amount. If additional funds remain, they are applied to the provider's disproportionate share hospital payment (DSH payment). The DSH payment is a supplement for network providers which is used to provide patient care and services not covered by IowaCare. If federal financial participation is not available because GME and DSH qualifying funds have reached the upper limit, any remaining PIP will be paid from 100% State funds. As illustrated by **Table 4**, only claims for UIHC have exceeded the PIP payment each year. The PIP allocation for the remaining providers is shown in the **Table**.

Table 4

Provider Name	Fiscal Year Ended June 30, 2006	2007	2008	2009
UIHC- PIP	$ 27,284,584	27,284,584	27,284,584	27,284,584
Payment Based on Claims	34,168,493	40,979,024	50,158,573	#
Applied as enhanced DSH	-	-	-	#
BMC- PIP	37,000,000	37,000,000	37,000,000	41,000,000
Payment Based on Claims	13,757,990	14,318,120	17,937,150	#
** Applied as enhanced DSH	22,869,040	22,681,880	^19,062,850	#
** Payment of 100% State funds	372,970	-	-	#
Cherokee MHI- PIP	9,098,425	9,098,425	9,098,425	3,164,766
Payment Based on Claims	7,290,009	3,303,972	5,000,436	#
Applied as enhanced DSH	1,808,416	5,794,454	4,097,989	#
Independence MHI- PIP	9,045,894	9,045,894	9,045,894	3,146,494
Payment Based on Claims	4,658,701	4,621,334	5,252,298	#
Applied as enhanced DSH	4,387,193	4,424,560	3,793,596	#
Mt. Pleasant MHI- PIP	5,752,587	5,158,345*	5,158,345*	2,000,961
Payment Based on Claims	861,833	393,948	408,475	#
** Applied as enhanced DSH	4,422,759	4,554,579	4,625,038	#
** Payment of 100% State funds	467,995	1,483,444	719,074	#
Clarinda MHI- PIP	1,977,305	1,977,305	1,977,305	687,779
Payment Based on Claims	1,122,125	347,428	674,362	#
Applied as enhanced DSH	855,180	1,629,877	1,302,943	#
Total applied as enhanced DSH	$ 34,342,588	39,085,350	32,882,416	#

 # - The fiscal year 2009 claim reconciliation report was not available as of the report date.

***^ -** BMC also received an additional $2,966,723, which increased the enhanced DSH payment to $22,029,573.*

******* - The maximum amounts have been applied to claims, GME and DSH. The remaining PIP obligation paid to the provider consists of 100% State funds.*

****** - Payments to Mt. Pleasant MHI were reduced in fiscal years 2007 and 2008 for 2 months of disallowed costs in each fiscal year.*

As illustrated by the **Table**, none of the PIP payments were allocated to GME. According to a representative of IME, GME applies only to UIHC and BMC. UIHC had sufficient claims to support the entire PIP payment and BMC's GME expense was paid from other sources.

The **Table** also shows a portion of the PIP payments received by BMC and Mt. Pleasant were allocated to 100% State funds. See **Funding H**.

- BMC did not have sufficient IowaCare claims, GME or DSH to support the PIP payments received in fiscal year 2006. An official of BMC was unable to specify how the portion of the PIP allocated solely to State funding was used; however, he stated the cost to administer the IowaCare program and provide services to enrollees exceeds the amount reimbursed by DHS. Accordingly, the State funding was used to offset those expenses. However, we were unable to obtain documentation to verify the use of the State funding because BMC did not separately record State funding in its ledger.
- The State funding provided to Mt. Pleasant MHI was used to offset a portion of the PIP allocation which was not eligible for federal matching dollars because a physician at the MHI was ineligible to participate in federal programs. In addition, the MHI did not have sufficient claims or DSH to support the PIP payments received in fiscal years 2006, 2007 and 2008. According to a representative of the MHI, the portion of the PIP allocated solely to State funding was used to pay operating expenses of the MHI.

In addition to the base appropriation, the General Assembly 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. UIHC has received payments from the supplemental appropriation (hereafter referred to as supplemental payments) each year since inception of IowaCare and BMC received supplemental payments in fiscal year 2009. UIHC did not use $3,694,439 of its supplemental appropriation for fiscal year 2006. However, that amount was carried forward and used during fiscal year 2007. **Table 5** lists payments to network providers from the IowaCare base and supplemental appropriations. See **Finding H**.

Table 5

Provider	Fiscal Year Ended June 30,				
Name	2006	2007	2008	2009	Total
UIHC (base)	$27,284,584	27,284,584	27,284,584	27,284,584	109,138,336
UIHC (supplemental)	6,883,909	13,694,439	22,873,989	30,419,272	73,871,609
BMC (base)	37,000,000	37,000,000	37,000,000	41,000,000	150,000,000
BMC (supplemental)	-	-	-	2,966,723	2,966,723
Cherokee MHI	9,098,425	9,098,425	9,098,425	3,164,766	30,460,041
Independence MHI	9,045,894	9,045,894	9,045,894	3,146,494	30,284,176
Mt. Pleasant MHI	5,752,587	5,158,345	5,158,345	2,000,961	18,070,238
Clarinda MHI	1,977,305	1,977,305	1,977,305	687,779	6,619,694
Total	$97,042,704	103,258,992	112,438,542	110,670,579	423,410,817

As shown by the **Table**, supplemental payments to UIHC since inception of the program total $73,871,609. For the fiscal year ended June 30, 2009, supplemental payments totaling $30,419,272 exceeded the base appropriation for fiscal year 2009 by $3,134,688. See **Finding I**.

As previously stated, UIHC and BMC also provide several services to IowaCare enrollees for which they are not reimbursed. UIHC and BMC each offer programs to assist enrollees

with access to durable medical equipment and prescription medications. UIHC also provides free transportation by appointment to any IowaCare enrollee who is unable to procure other transportation to Iowa City. In addition, UIHC operates an assistance center for IowaCare patients and, effective July 1, 2008, BMC opened a Primary Care Clinic to provide enrollees with a medical home. **Tables 6** and **7** show the value of these services, as reported by UIHC and BMC. The value of the BMC Primary Care Clinic is not included in **Table 7** because it was not reported by BMC. See **Finding E**.

Table 6

Unreimbursed Services	Fiscal Year Ended June 30, 2006	2007	2008	2009	Total
UIHC:					
Pharmacy and Durable Medical Equipment	$ 1,819,622	3,911,588	5,354,673	5,836,865	16,922,748
Assistance Center	652,628	868,631	1,008,398	1,089,840	3,619,497
Transportation	1,055,667	1,040,150	1,111,389	1,098,861	4,306,067
Physician Services	9,533,236	11,530,917	13,934,851	20,961,317	55,960,321
Total	$13,061,153	17,351,286	21,409,311	28,986,883	80,808,633

Table 7

Unreimbursed Services	Calendar Year Ended December 31, 2005	2006	2007	2008	Total
BMC:					
Pharmacy and Durable Medical Equipment	$ 3,075,000	2,572,855	4,334,000	4,450,000	14,431,855

As shown in **Table 6**, UIHC is not reimbursed for physician services provided to IowaCare enrollees by medical staff of the Carver College of Medicine. This is because the predecessor program to IowaCare, State Papers, did not allow UIHC to receive reimbursement for physician services and, according to the Director of DHS-IME, legislators wanted to preserve that requirement when transitioning from State Papers to the IowaCare program. The larger-than expected enrollment in the IowaCare program has led to an increased burden on UIHC and the hospital's ability to absorb the cost of physician services, which have more than doubled from approximately $9.5 million in FY06 to approximately $21 million in FY09.

BMC is provided with reimbursement for physician services provided to IowaCare enrollees because BMC must submit a sufficient amount of IowaCare claims to recoup the Polk County tax dollars transferred to the IowaCare account each year. See **Finding J**.

As shown by **Tables 6** and **7**, UIHC and BMC have contributed a combined total of more than $95,000,000 from sources other than the IowaCare account to supplement benefits for IowaCare enrollees.

Monitoring

As previously stated, information reported on IowaCare applications is self-declared, including income, number of household members, age or access to group health insurance, and is not required to be verified. If verification is requested, the applicant must be notified in writing and has 5 days to respond. Applications must be approved within 3 working days, but exceptions exist to allow DHS–IME staff time to verify application information or to determine if the applicant is eligible for Medicaid. Once eligibility has been determined, approval is granted for a 12 month period even if changes occur in income or household size.

From November 1, 2005 through October 31, 2006, DHS conducted a quality control pilot program. The purpose of the pilot program was to determine if information declared on IowaCare applications was accurately reported. DHS selected 399 IowaCare case files to examine for quality control. Workers reviewed age, alien status, residency, household composition and relationship, income, health insurance coverage, application processing standards and determined whether the applicant would have been eligible for another Medicaid coverage group. Based on the review, DHS identified errors in 89, or 22%, of the 399 cases reviewed. The errors included 7 ineligible cases, 46 cases where the premium was understated and 36 cases where the premium was overstated. Error reports were provided to the local county office for corrective action. Based on results of the pilot program, DHS officials concluded applicants make an effort to accurately self-declare application information. However, given an error rate of 1 in 5 case files, further ongoing review by officials of DHS is warranted.

DHS has not performed a detailed quality control review of IowaCare case files since the pilot program completed on October 31, 2006. See **Finding K**.

Program Goals

As previously stated, the Legislature established the IowaCare program effective July 1, 2005 as part of an initiative to reform the State's Medicaid program. Specifically, IowaCare was designed to replace the State's former indigent care program, State Papers, which was federally funded through a mechanism know as Intergovernmental Transfers (IGT's). Because CMS was phasing-out IGT's, the State was positioned to lose approximately $65 million annually allotted to provide health care services to low-income Iowan's who did not otherwise categorically qualify for Medicaid.

Specific objectives designed for the IowaCare program are outlined in the Draft Evaluation Design, a document required to be prepared and submitted to CMS within 120 days of approval of the waiver to detail program objectives and methods of evaluation. Based on the Draft Evaluation Design, we identified 4 targeted objectives of the IowaCare program. The objectives are listed below and will be discussed in the following paragraphs:

- Improve access to appropriate health care,
- Incentivize consumers to engage in responsible health care utilization and personal health care management,
- Increase support for safety net hospitals and
- Rebalance the state's mental health system.

In January 2008, the University of Iowa Public Policy Center released a report of evaluation of the IowaCare program. The evaluation was requested by DHS-IME personnel to satisfy requirements of the waiver and is the first of several evaluations to be conducted. The evaluation results were developed based on a survey of IowaCare enrollees. The report provides statistics about enrollee characteristics, health status, program administration, program utilization, access to care and quality of care. It also includes the results of provider comments and perspectives obtained by conducting provider focus groups.

We reviewed the outcomes identified in the evaluation, statistical reports available on DHS-IME's website and data obtained from other sources, such as the IowaCare Annual Reports, to determine if IowaCare has achieved favorable results for the goals established in the Draft Evaluation Design.

Improved access to appropriate health care

- *Approximately 15,000 uninsured adults will receive limited Medicaid insurance coverage.*

  According to statistical reports generated from DHS-IME's website, enrollment in IowaCare at June 30, 2009 was 31,986. Actual enrollment is more than twice the target enrollment.

- *Access to care will improve.*

  According to the survey results, 62% of respondents indicated they did not have insurance coverage for more than 2 years prior to enrolling in IowaCare. Only 12% of the respondents were previously enrolled in State Papers.

  Of 1,048 survey respondents, 381 indicated they received care outside the provider network between 1 and 4 times. As previously stated, the IowaCare provider network is limited to BMC, UIHC and the State's MHIs.

  Survey results show 54% of respondents indicated a situation arose in the 6 months prior to the survey date which required immediate care. Of those immediate care visits, 34% were to providers outside the IowaCare network.

  In non-emergency situations, 18% of respondents indicated they visited a non-IowaCare provider 4 or more times in the 6 months prior to the survey date. According to survey results, the respondents noted unmet needs for care in the following categories:

Routine Care 36%	Specialty Care 37%
Urgent Care 37%	Mental/Behavioral Care 39%
Preventative Care 23%	Dental Care 33%

  According to the evaluation, the most common reasons cited for reporting an unmet need for routine care included inability to pay for care, transportation issues, limited benefits and trouble obtaining an appointment. Survey results show 33% of respondents reported appointments for routine care were sometimes or never available when needed.

  In addition, 36% of survey respondents stated they were unable to fill a medication prescription. According to the survey, durable medical equipment is needed for 11% of enrollees. Survey results show 4 out of 10 who require durable medical equipment were unable to obtain the necessary equipment.

- *Utilization of medical, dental, behavioral and emotional and pharmacy services will increase.*

  Of the survey respondents, 87% indicated they used IowaCare for most or all of their healthcare needs. Of those that used IowaCare, 61% noted they accessed IowaCare benefits in the 6 months prior to the survey date.

  Survey results show 1 in 5 respondents attempted to access dental care at UIHC or BMC. Of those who attempted to access care, 60% had at least 1 dental visit. Dental care was reported more accessible by Polk County residents.

  Survey results show 28% of respondents required treatment or counseling for a mental or emotional problem. For those who reported a need, 75% reported receiving care for their mental or emotional problem. However, 57% who received care obtained it outside the IowaCare provider network. Less than 1% received care at the State MHIs.

Survey results show 75% of respondents reported the need to fill a prescription. For those who needed a prescription filled, 90% were prescribed to treat a chronic condition and 65% of the time prescriptions were filled by UIHC or BMC.

As previously stated, durable medical equipment is required for 11% of enrollees. Of those who required medical equipment, 44% were able to obtain the equipment from UIHC or BMC. Medical equipment was obtained from other sources for 46% of respondents. Results for the remaining 10% of enrollees requiring medical equipment are not known.

- *The quality of care received by this population will be appropriate.*

Survey results show 4 of 10 enrollees rated the care they received as a 9 or 10 on a scale of 1 to 10, with 10 being the best. For Polk County residents accessing care at BMC, 69% rated the plan at a 7 or above on a scale of 1 to 10. For enrollees accessing care at UIHC, 67% rated the plan at 7 or above on a scale of 1 to 10. In addition, more than half of survey respondents would recommend the IowaCare plan to others. Only 6% of respondents reported they probably or definitely would not recommend IowaCare.

- *The health status of this population will remain constant or improve over time.*

Based on self-reported information, the overall health-care status of IowaCare enrollees rated lower than for non-disabled Medicaid enrollees. Of the enrollees surveyed, 90% of respondents indicated they had at least 1 health condition that persisted for at least 3 months. The most commonly reported chronic condition was dental problems. Other high-ranking conditions reported were neck or back problems, arthritis, bone or joint problems and hypertension.

- *Care coordination will improve.*

Approximately 80% of enrollees with a personal doctor received care from another doctor in the past 6 months. Of the respondents who reported receiving care from more than one physician, 75% received some care-coordination assistance. Of those receiving care-coordination assistance, 80% were very satisfied or satisfied with the care received. The remaining 20% noted their personal doctor was either sometimes or never informed about the care provided by the other physician.

<u>Incentivize consumers to engage in responsible health care utilization and personal health care management</u>

- *An insurance model using sliding premiums instead of copayments will be affordable for enrollees.*

According to the enrollee survey, 26% of respondents were required to pay premiums. Of those required to pay a premium, 29% reported they worried a great deal about their ability to pay and 26% worried somewhat about their ability to pay. Approximately 25% of respondents reported filing a hardship declaration to waive the premium.

According to statistical reports available on DHS-IME's website, 21,653 enrollees were disenrolled for failure to pay the premium. Of those disenrolled, only 5,980 were subsequently re-enrolled the following month after paying the premiums due.

- *Wellness and preventative health measures will increase.*

  According to the IowaCare Annual Reports, 764 unique IowaCare members had physical exams during fiscal year 2008 and 527 unique IowaCare members had physical exams during fiscal year 2009.

  In addition, personal improvement plans have not been used as frequently as expected. According to discussions with the Director of IME, the expected group of IowaCare enrollees was low-income healthy Iowans. However, many IowaCare enrollees suffer from chronic conditions for which they are seeking treatment and care. Accordingly, wellness plans are incorporated into the treatment received for the chronic conditions.

Increase support for safety net hospitals

- *UIHC will provide more indigent care services (number of people and number of services) than during the previous indigent care program.*

  The State Papers program served approximately 5,000 participants. Enrollment in IowaCare at June 30, 2005 totaled 31,986.

- *UIHC will receive increased support for care for the indigent than during the previous indigent care program.*

  The annual base appropriation to UIHC for IowaCare has remained steady at $27,284,584. However, in addition to the base appropriation, UIHC has received $73,871,609 of supplemental payments from July 1, 2005 through June 30, 2009. Appropriations to UIHC for State Papers in fiscal years 2003, 2004 and 2005 totaled $28,158,909, $27,354,545 and $27,284,584, respectively.

  Enrollment in IowaCare has increased 6-fold over enrollment in the State Papers program. According to data provided by UIHC, UIHC has absorbed $80,808,633 of unreimbursed costs for services, pharmaceuticals and medical equipment provided to IowaCare enrollees from July 1, 2005 through June 30, 2009.

- *Safety net hospital providers and administrators will perceive an increase in the ability to care for patients who were previously uninsured (this will include all 6 participating facilities).*

  The University of Iowa Public Policy Department conducted administrator and provider focus groups as part of its evaluation process. Results of the focus groups show:

  - Some barriers to access program services include inability of some applicants to obtain a valid birth certificate, shortage of psychiatrists in the MHI's, the volume of enrollees, the lack of coverage for prescriptions and medical equipment and the distance of travel required to UIHC. Because IowaCare does not cover needed pharmacy items and medical equipment, UIHC and BMC have implemented self-funded programs to provide prescription medication and medical equipment to enrollees when possible.

  - Overall, the application process is easy. However, UIHC representatives noted some patients who are not eligible for IowaCare submit applications because it is known that income and assets are not verified.

  - IowaCare enrollees seek care outside the IowaCare provider network due to delays in appointment scheduling as a result of the volume of patients served.

Rebalance the state's mental health system

- *Expansion of assertive community assistance will reduce avoidable hospitalizations over time (chronically mentally ill population only).*

  DHS-IME was unable to provide us with statistical information to determine progress made towards this goal.

- *Access to mental health care will improve.*

  Survey results show 28% of respondents needed treatment or counseling for a mental or emotional problem. Of the 28% reporting a need for treatment, 72% received mental health treatment. Of the respondents who received treatment, 57% reported they received mental health services outside the provider network.

  In addition, 39% indicated on at least 1 occasion they could not obtain the mental health services they needed. Reasons cited for inability to access care include the care needed is not a covered benefit, prescriptions were not affordable, difficulty obtaining an appointment and transportation was not available.

- *Utilization of behavioral and emotional care received by the population will be appropriate.*

  According to survey results, 28% of respondents reported they needed mental health services in the 6 months prior to the survey date. 72% of those seeking mental health services received the services they needed, but only 43% of them accessed care within the IowaCare network. Of the survey respondents, 62% who received mental health care rated the care they received at a 7 or above on a scale of 1 to 10.

- *The mental health status of this population will remain constant or improve over time.*

  According to the Draft Evaluation Design, the primary measurement for this goal is enrollee survey results. However, we are unable to determine if a trend towards improved mental health exists because only 1 enrollee survey has been completed to date. The results from a second survey are scheduled to be released in early 2010.

- *Care coordination between physical and mental health providers will improve.*

  According to the Draft Evaluation Design, the primary measurement for this goal is enrollee survey results. However, we are unable to determine the status of care coordination between physical and mental health providers because the enrollee survey results do not address outcomes of care coordination specific to mental health care.

Provider Perspective, Renewal and Other Compliance

Provider Perspective – UIHC and BMC have made several presentations to legislative committees. We reviewed the comments made by officials of UIHC and BMC to obtain an understanding of the providers' perspective of IowaCare.

Specifically, we identified the following significant items noted by officials of UIHC:

- UIHC subsidizes the IowaCare program with donated physician services, pharmaceuticals and durable medical equipment, transportation services and the cost to administer an IowaCare assistance center.

- Several hundred cases where patients have primary insurance coverage that makes payments yet the individual is listed by DHS as IowaCare eligible.
- Administrators at UIHC would like to see application information verified.
- UIHC could not reach a 28E agreement with DHS-IMS because of outstanding issues such as eligibility verification, administrative costs and a hold-harmless provision for future legislative actions.
- Administrators would like to see the provider network expanded, reimbursement for physician services and coverage for pharmaceuticals.

Administrators of BMC identified the following:

- BMC subsidizes the IowaCare program with pharmaceuticals and durable medical equipment, as well as the administration of an IowaCare assistance center.
- BMC would like to see outstanding premiums forgiven for enrollees who were disenrolled from the program for failure to pay premiums, specifically for those with income below 100% of the poverty threshold.
- BMC could not reach a 28E agreement with DHS-IME because DHS-IME indicated it was unable to pay administrative costs for IowaCare.
- Administrators indicated concerns for the program include the ability to manage growth given funding limitations and would like to see DHS-IME improve access to care for enrollees.

Plans for Renewal – As previously stated, the IowaCare program was approved for a 5 year period from July 1, 2005 through June 30, 2010. A renewal waiver is currently in process. According to the renewal proposal, DHS-IME will request the waiver be renewed for an additional 3 year period.

The renewal waiver proposal includes the expansion and spend-down pregnant women populations. DHS-IME has requested the emotionally disabled children group be moved to a separate waiver, which is consistent with how it is currently reported.

The waiver renewal also includes new requests, such as the ability to make amendments if a "Medicaid expansion is enacted by Congress that would overlap some or all of the IowaCare Demonstration populations, while continuing the waiver for populations not covered by the Medicaid expansion." In addition, the waiver requests a provision to allow the State be able to "expand the provider network to improve local access to health care."

The waiver also seeks to remove certain items, such as terms and conditions that prohibit the State from establishing new provider taxes and a cap on payments to public institution providers at actual cost.

Other items for consideration of the waiver renewal include the ability to provide expanded services for mental health inpatient benefits and those receiving limited State Plan benefits by making disproportionate share hospital payments to the State's MHIs.

Other Compliance – We reviewed selected sections of Chapter 249J of the *Code of Iowa* to determine if DHS-IME was administering the IowaCare Act in accordance with the requirements of the *Code.* We identified several areas of non-compliance which are discussed in the following paragraphs.

- According to section 249J.8 of the *Code of Iowa*, DHS-IME shall submit to the General Assembly a design of an insurance cost subsidy program for expansion population members who have access to employer health insurance plans, provided the design shall require no less than 50% of the cost of such insurance shall be paid by the employer. In addition, DHS-IME is also required to submit to the General Assembly a design of a health care account program option for individuals eligible for enrollment in the expansion population. A consensus on the design for these programs was never reached. See **Finding L**.

- Section 249J.12 of the *Code of Iowa* specifies DHS-IME shall develop a case-mix adjusted reimbursement plan for institution and community-based services and submit the plan to the General Assembly by January 1, 2007. According to a study conducted for DHS-IME by the Iowa Health and Disability Resource Center at UIHC, the purpose for a case-mix adjusted reimbursement plan is to match client needs to the reimbursement provided for an appropriate level of service. The goal is to increase cost-effectiveness while improving quality and availability of care. According to the IowaCare Program Director, a plan was not developed or submitted because specific research findings for this topic were lacking and funding was not appropriated. See **Finding M**.

- According to section 249J.15 of the *Code of Iowa*, the Task Force on Indigent Care shall meet at least 8 times each fiscal year to identify any growth in uncompensated care due to the implementation of the IowaCare Act and to identify any local funds being used to pay for uncompensated care that could be maximized through a match with federal funds. Any public or private health provider or payor or organization of providers or payors may become a member of the Task Force. DHS-IME has not convened the Task Force and, accordingly, the Task Force on Indigent Care has not met. See **Finding N**.

- According to section 249J.16 of the *Code of Iowa,* DHS-IME shall contract with an independent consulting firm to annually evaluate and compare the cost and quality of care provided by the medical assistance program and through the expansion population with the cost and quality of care available through private insurance and managed care organizations doing business in the state. In addition, DHS-IME shall annually evaluate the improvements by the medical assistance program and the expansion population in the cost and quality of services provided to Iowans over the cost and quality of care provided in the prior year. DHS-IME officials provided us with various cost and quality reports but none were specific enough in scope to meet the requirements of the *Code.* See **Finding O**.

- According to section 249J.20 of the *Code of Iowa*, the Medical Assistance and Projections Council (MAPC) shall meet at least quarterly 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. The MAPC met only 1 time during fiscal year 2008 and did not meet at all during fiscal year 2009. In addition, quarterly reports have not been formally reviewed by the MAPC. See **Finding P**.

- Section 249J.24 of the *Code of Iowa* requires DHS-IME to execute 28E agreements annually with UIHC and BMC to specify the requirements of distribution of monies from the IowaCare account to the hospitals. In addition, the agreement should include other provisions specified by the *Code*. Agreements were not reached for the fiscal years ended June 30, 2008 and 2009. According to discussions with officials of DHS-IME and UIHC, agreements could not be reached for several reasons, including differing opinions about how to handle

administrative costs and hold-harmless provisions regarding future legislative actions. See **Finding Q**.

- On July 23, 2008, $2,000,000 was transferred from the IowaCare account to the General Fund for Medicaid. According to section 249J.24 of the *Code of Iowa*, funds in the IowaCare account are not to be "transferred, used, obligated, appropriated or otherwise encumbered, except for the purposes of this Chapter." The transfer was made to ensure funds were available in the General Fund to pay Medicaid claims. According to DHS personnel, on July 25, 2008, the calculated draw of matching federal funds for IowaCare was supplemented with $2,000,000 from the regular Medicaid draw to restore the transferred funds to the IowaCare account. See **Finding R**.
- On September 15, 2006, DHS made a $613,089.55 entry to the IowaCare account to carry-forward premium collections to the next fiscal year. However, the entry was erroneously coded to federal revenues. The error was not identified until September 15, 2007. When the error was identified, an adjusting entry was made to move the $613,089.55 from federal revenues to premiums. In addition, DHS did not timely draw eligible federal funds to the IowaCare account during fiscal year 2006. Eligible funds were drawn during fiscal year 2007 and carried-back to fiscal year 2006. See **Finding S**.

According to the Director of IME, a shift in the approach to health care by the General Assembly caused formation of several committees which took on the roles of the Task Force on Indigent Care and the Medical Assistance and Projections Council. In addition, other statutory requirements, such as the insurance cost subsidy plan, the health care account program option and the case-mix adjusted reimbursement plan never materialized because of changes in the legislative focus and a lack of financial resources.

In conjunction with the IowaCare renewal waiver previously discussed, on January 14, 2010, officials of DHS-IME submitted House Study Bill 570 for legislative consideration of proposed modifications to Chapter 249J of the *Code of Iowa*. The proposed changes include revisions to and repeals of several requirements which were not complied with by DHS-IME during the first 5 years of the IowaCare Act, including requirements noted above for sections 249J.8, 249J.12, 249J.15 and 249J.16 of the *Code*.

Other States

We reviewed the CMS website to determine if other states administer similar waivers established in accordance with section 1115 of the Social Security Act. As of our report date, we identified 12 states in addition to Iowa currently operating healthcare programs authorized by 1115 waiver authority geared towards population groups similar to IowaCare. The programs serve childless adults or low-income adults with children who do not qualify for Medicaid.

Like IowaCare, many of the programs base eligibility primarily on income, with limits ranging from 0-200% of the federal poverty level. The states we identified are Arizona, Delaware, Indiana, Maine, Maryland, Michigan, Minnesota, New York, Oregon, Utah, Vermont and Wisconsin. **Table 8** shows a comparison of the other states' program structure to that of IowaCare based on program fact sheets obtained from the CMS website.

Table 8

State	Premiums	Co-Payments	Deductible	* Upper Income Limitation	Estimated Enrollees
Arizona	Yes	Yes	No	200% FPL	48,250
Delaware	No	Yes	No	100% FPL	NA
Iowa	Yes	Yes	No	200% FPL	14,000
Indiana	^ Yes	Yes	Yes	200% FPL	NA
Maine	No	Yes	Yes	100% FPL	20,000
Maryland	No	Yes	No	200% FPL	20,000
Michigan	No	Yes	No	35% FPL	62,000
Minnesota	Yes	Yes	No	215% FPL	NA
New York	No	Yes	No	100% FPL	425,000
Oregon	Yes	Yes	No	185% FPL	NA
Utah	Yes	Yes	No	150% FPL	NA
Vermont	Yes	Yes	No	200% FPL	NA
Wisconsin	No	Yes	No	200% FPL	NA

***** - *Based on guidelines established for childless adult eligibility groups. FPL stands for federal poverty level.*

^ - *Plan requires enrollee contributions to a POWER account structured like a Health Savings Account.*

NA – Estimated enrollee data was not provided on the fact sheet.

Findings and Recommendations

We reviewed the IowaCare program 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 the IowaCare program was administered in compliance with applicable laws, rules and guidelines and to determine if the IowaCare program has met program goals and expectations.

FINDING A - Annual Certification

According to section 441-92.3 of the Iowa Administrative Code, once eligibility has been determined, approval is granted for a 12 month period even if changes occur in income or household size. In addition, section 441-92.7 of the Iowa Administrative Code specifies the amount of the premium will not be increased even if household income increases or household size decreases. However, premiums can be adjusted down for the alternative.

Recommendation – The General Assembly and DHS-IME should consider a modification to the *Code* to allow for a premium increase as is currently allowed for a premium decrease.

FINDING B - Database of IowaCare Enrollees

Officials of DHS-IME provided a database of IowaCare enrollees to use for selection of cases to review for eligibility compliance and calculation of the premium assessment. To determine if the database was complete, we compared the number of enrollees to statistical reports of IowaCare enrollment statistics available on DHS-IME's website. In addition, we compared the cases files selected by DHS for review as part of the quality

control pilot to determine if they were included in the database of IowaCare enrollees provided to us by officials of DHS-IME.

We determined the number of enrollees in the database materially agreed to statistical enrollment data available on DHS-IME's website. However, we were unable to locate 18 of the 399 DHS quality control case files on the database. We were unable to determine why the cases were not included on the database.

Recommendation – DHS-IME should review the criteria used to prepare the database to identify weaknesses which resulted in an incomplete database.

FINDING C – Eligibility Compliance

We identified instances of incomplete case files and non-compliance with eligibility requirements.

- According to section 441-92.4 of the Iowa Administrative Code, applications should be approved or denied within 3 working days, unless certain conditions exist. We identified 8 applications which were not approved in the allowed time period and circumstances surrounding the delay were not noted in the case file.
- Section 441-92.3 of the Iowa Administrative Code requires applicants who submit an allowed application other than the IowaCare application also to submit a signed IowaCare premium agreement. We identified 8 applications which required a premium agreement but an agreement was not located in the case file.
- Section 441-92.2 of the Iowa Administrative Code specifies enrollees must pay incurred and unpaid premiums from a previous enrollment before new enrollment can be established. We noted 1 approved application for an enrollee who had outstanding premiums from a prior enrollment. We could not locate documentation in the case file to show the outstanding premiums due were paid.
- We identified 2 of 75 applications in which the applicant reported access to group health care and was approved for program services. In certain circumstances, enrollees may also carry group health care and remain eligible for IowaCare services, but the case file should adequately document the basis used to determine eligibility. An additional 7 applications appeared questionable if the applicant had access to an employer-sponsored health plan.
- We identified 13 of 75 case files for which we could not locate a corresponding "Notice of Decision" to show the application approval status, the income or household count used to determine eligibility or the amount of premium assessed. For these applications, we were unable to determine if the application was approved or denied in compliance with the eligibility requirements.
- We identified an application which was denied because the applicant's spouse had outstanding premiums. We were unable to locate specific guidance to address this circumstance. However, because the applicant was applying as an individual, it appears the application was improperly denied.
- We identified a case file showing documentation of approval for IowaCare, but we could not locate the application.

Recommendation – DHS-IME should implement procedures which ensure compliance with all eligibility requirements when approving IowaCare applications. In addition, case files should be complete and adequately documented.

FINDING D - Verification of Application Information

Per section 441-92.4 of the Iowa Administrative Code, IowaCare applicants are not required to provide verification of income, household numbers, disability, social security number, age, HAWK-I premium, group health insurance or pregnancy unless the verification is specifically requested in writing.

We identified 7 of 75 applications which raised questions about the availability of group health care for the applicant and their eligibility for enrollment in IowaCare. In addition, it was reported by officials of UIHC some individuals have submitted applications to enroll in IowaCare based on falsified application information because of the lack of verification of self-reported data.

Recommendation – DHS-IME should consider verification of self-reported application information to improve the accuracy of application data and reduce the risk of IowaCare program approval for individuals who do not qualify for program services.

FINDING E - Provider Network and Benefits

The provider network consists of Broadlawns Medical Center, the University of Iowa Hospitals and Clinics and the State's MHIs.

Based on our review of enrollee county residence, approximately 50% of enrollees live in Polk County, Johnson County (home of UIHC) and counties surrounding Johnson County. As a result, access to care can be difficult, especially for enrollees who reside outside Polk County and do not live near Iowa City. The IowaCare Act was amended during the 2009 legislative session to allow non-participating provider reimbursement for the IowaCare program under certain circumstances. However, funding was not provided for additional reimbursements so DHS-IME had not taken action to act on the amendment.

IowaCare benefits may vary depending on the services offered by the provider because providers have the ability to choose the level of services provided. For example, dental care is listed as a benefit of IowaCare. However, UIHC provides only tooth extractions while BMC provides some limited restorative care. As a result, only Polk County residents receive the benefit of restorative care.

In addition to services covered by IowaCare, UIHC and BMC offer programs to assist with access to durable medical equipment and prescription medications. UIHC also provides free transportation by appointment to any IowaCare participant who is unable to procure other transportation to Iowa City. UIHC and BMC also provide assistance centers for IowaCare enrollees. These costs are absorbed by the providers and are not reimbursed from the IowaCare account.

Recommendation – The General Assembly and DHS-IME should evaluate the impact of the IowaCare program on access to health care by qualified Iowans. In addition, the General Assembly and DHS-IME should review the benefit structure to determine if it is appropriate for the provider to have the ability to choose the level of services provided. Inconsistent application of benefits can create confusion for enrollees about which provider services are a covered benefit of IowaCare.

Also, the General Assembly and DHS-IME should evaluate options to address the unreimbursed coverage by UIHC and BMC for durable medical equipment and prescription medications provided to enrollees.

FINDING F - Premium Hardship Claims

Enrollees who are unable to pay part or all of their monthly premium may declare a hardship exemption by submitting, in writing, the monthly premium would be a financial hardship. If the written statement is received by the premium due date, the monthly premium is forgiven and benefits remain intact. There is no limit on the number of hardship exemptions which may be submitted and all hardship requests are granted. According to IowaCare statistical reports available on DHS-IME's website, 94,127 hardship claims totaling $4,136,554 have been received by DHS-IME, which account for 41% of billed premiums.

Recommendation – The General Assembly and DHS-IME should review the hardship exemptions effect on program income and the overall impact to the IowaCare program. In addition, because a key component of the IowaCare waiver was shared financial responsibility for enrollees, the General Assembly and DHS-IME should determine if the ability for enrollees to claim unlimited hardship exemptions conflicts with the intent of the program.

FINDING G - Premium Testing

We obtained 35 case files which included 29 applications for which a monthly premium was assessed. We examined the 29 applications to determine if premiums were properly calculated and assessed based on the self-declared application information.

We could not recalculate assessed premiums for 4 applications because adequate documentation was not provided in the case file to determine the poverty threshold and household size used by DHS case workers to determine the monthly premium.

In addition, for 3 applications we identified a variance between the number of household members declared on the application and the number of household members used to assess the monthly premium. However, the case file did not provide adequate documentation to determine why the variance existed.

According to Iowa Administrative Code section 441-92.5(4), the first $50.00 of child support income is exempt from the applicant's income when assessing the monthly premium. We identified 2 applications for which child support was reported as income but the applicant was not provided a $50.00 exemption.

An additional 12 applications resulted in a difference between the income reported on the application and the income used to assess the monthly premium. Of the 12 applications, 4 did not provide adequate documentation to determine why the variance existed. Another 6 were modified as a result of verification of the applicant's income. Monthly income of $846.16 for 1 application was not used in the assessment of the premium. The remaining application variance was due to a child-support deduction for which the case-worker subtracted directly from the income instead of reporting the full income and subtracting the allowable exclusion.

Also, for 1 application the premium was not properly calculated based on the federal poverty level guidelines.

Recommendation – DHS-IME should review procedures to determine if procedures are adequate to ensure premiums are properly calculated and assessed. In addition, case files should contain adequate documentation to support the amount of the premium assessed. An explanation for differences between the application information and the information used to determine the premium should be documented in the case file.

FINDING H – PIP Cost Settlement

A portion of the PIP payments received by BMC and Mt. Pleasant MHI were allocated to 100% State funding.

- BMC did not have sufficient IowaCare claims, GME or DSH to support the PIP payments received in fiscal year 2006. An official of BMC was unable to specify exactly how the PIP allocated solely to State funding was spent; however, he stated the cost to administer the IowaCare program and provide services to enrollees exceeds the amount reimbursed by DHS. Accordingly, the State funding was used to offset those expenses. However, we were unable to obtain documentation to verify the use of the State funding because BMC did not separately record State funding in its ledger.

- The State funding provided to Mt. Pleasant MHI was used to offset a portion of the PIP allocation which was not eligible for federal matching dollars because a physician at the MHI was ineligible to participate in federal programs. In addition, the MHI did not have sufficient IowaCare claims or DSH to support the PIP payments received in fiscal years 2006, 2007 or 2008. According to a representative of the MHI, the portion of the PIP payment allocated solely to State funding was used to pay operating expenses of the MHI.

Recommendation – Because some providers received payments in excess of the cost of services provided, the General Assembly and DHS-IME should determine if this funding process should continue or if excess funds should be reverted to the program.

FINDING I - Program Growth and Supplemental Payments

Officials of DHS-IME originally estimated approximately 14,000 Iowans would be served by IowaCare. At the end of fiscal year 2009, IowaCare enrollees totaled 31,984. During the fiscal year ended June 30, 2009, 45,213 unique members were enrolled in IowaCare.

Providers are awarded additional funding only if it has been appropriated by the General Assembly. UIHC has received supplemental payments in addition to the base appropriation of $27,284,584 each year since inception of IowaCare to help manage continued program growth. The supplemental payments to UIHC total $73,871,609. For the fiscal year ended June 30, 2009, supplemental payments to UIHC exceeded the base appropriation by $3,134,688.

Recommendation – The General Assembly and DHS-IME should give careful consideration to the State's ability to maintain the IowaCare program if unrestricted enrollee growth continues.

FINDING J - Physician Reimbursement

UIHC is not reimbursed for physician services provided to IowaCare enrollees by medical staff of the Carver College of Medicine. This is because the predecessor program to IowaCare, State Papers, did not allow UIHC to receive reimbursement for physician services and, according to the Director of DHS-IME, legislators wanted to preserve that requirement when transitioning from State Papers to IowaCare. The larger-than expected enrollment in the IowaCare program has led to an increased burden on UIHC and its ability to absorb the cost of physician services, which has more than doubled from approximately $9.5 million in FY06 to approximately $21 million in FY09.

BMC is provided with reimbursement for physician services provided to IowaCare enrollees because BMC must submit a sufficient amount of IowaCare claims to recoup the Polk County tax dollars transferred to the IowaCare account each year.

Recommendation – The General Assembly and DHS-IME should consider options available to address the financial burden placed on UIHC as a result of the lack of reimbursement for physician services.

FINDING K - Quality Control

From November 1, 2005 through October 31, 2006, DHS conducted a quality control pilot program. Through the pilot program, DHS selected 399 IowaCare case files to determine if self-declared information was correct. Workers reviewed age, alien status, residency, household composition and relationship, income, health insurance coverage, application processing standards and determined whether the applicant would have been eligible for another Medicaid coverage group. Based on the review, DHS identified errors in 89 of the 399 cases reviewed. The errors included 7 ineligible cases, 46 cases where the premium was understated and 36 cases where the premium was overstated. Error reports were provided to the local county office for corrective action. Based on results of the pilot, DHS officials concluded applicants make an effort to accurately self-declare application information.

DHS has not performed a detailed quality control review of IowaCare case files since the pilot program completed on October 31, 2006.

Recommendation – DHS should implement quality control procedures to determine on an ongoing basis if self-reported information is correct. In addition, DHS should monitor compliance with eligibility requirements and application processing to ensure case files are complete and accurate.

FINDING L - Insurance Cost Subsidy Program and Health Care Account Program

According to section 249J.8 of the *Code of Iowa*, DHS-IME shall submit a design to the General Assembly an insurance cost subsidy program for expansion population members who have access to employer health insurance plans, provided that the design shall require that no less than fifty percent of the cost of such insurance shall be paid by the employer. In addition, DHS-IME shall submit a design to the General Assembly a health care account program option for individuals eligible for enrollment in the expansion population.

A consensus of design for these programs was never reached.

Recommendation – DHS-IME should reach a consensus for design of these programs and submit the results to the General Assembly.

FINDING M - Case-Mix Adjustment Plan

Section 249J.12 of the *Code of Iowa* specifies DHS-IME shall develop a case-mix adjusted reimbursement plan for institution and community-based services and submit the plan to the General Assembly by January 1, 2007. According to the IowaCare Program Director, a plan was not developed or submitted because specific research findings for this topic were lacking and funding was not appropriated.

Recommendation – DHS-IME should develop and submit a plan for case-mix adjustment to the General Assembly as required by the *Code.*

FINDING N - Task Force on Indigent Care

According to section 249J.15 of the *Code of Iowa*, the Task Force on Indigent Care shall meet at least 8 times each fiscal year to identify any growth in uncompensated care due to the implementation of the IowaCare Act and to identify any local funds being used to pay for

uncompensated care that could be maximized through a match with federal funds. The Task Force on Indigent Care has not met.

Recommendation – The Task Force on Indigent Care should meet a minimum of 8 times each fiscal year to perform its specified functions, as required by the *Code.*

FINDING O – Cost and Quality Performance Evaluation

According to section 249J.16 of the *Code of Iowa,* DHS-IME shall contract with an independent consulting firm to annually evaluate and compare the cost and quality of care provided by the medical assistance program and through the expansion population with the cost and quality of care available through private insurance and managed care organizations doing business in the state. In addition, DHS-IME shall annually evaluate the improvements by the medical assistance program and the expansion population in the cost and quality of services provided to Iowans over the cost and quality of care provided in the prior year. DHS-IME officials provided us with various cost and quality reports but none were specific enough in scope to meet the requirements of the *Code.*

Recommendation – DHS-IME should annually contract with an independent consulting firm to compare the cost and quality of care provided by the medical assistance program and through the expansion population with the cost and quality of care available through private insurance and managed care organizations doing business in the state. In addition, DHS-IME officials should evaluate the improvements in cost and quality of care to the prior year.

FINDING P - Medical Assistance and Projections Council

According to section 249J.20 of the *Code of Iowa*, the Medical Assistance and Projections Council (MAPC) shall meet at least quarterly 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.

The MAPC met only 1 time during fiscal year 2008 and did not meet at all during fiscal year 2009. In addition, quarterly reports have not been formally reviewed by the MAPC.

Recommendation – The MAPC should meet at least quarterly to perform its specified functions, as required by the *Code.*

FINDING Q - Execution of 28E Agreements

Section 249J.24 of the *Code of Iowa* requires DHS-IME to execute 28E agreements annually with UIHC and BMC to specify the requirements of distribution of monies from the IowaCare account to the hospitals. In addition, the agreement should include other provisions, as specified by the *Code*. Agreements were not reached for the fiscal years ended June 30, 2008 and June 30, 2009. According to discussions with officials of DHS-IME and UIHC, agreements could not be reached for several reasons, including differing opinions about how to handle administrative costs and hold-harmless provisions regarding future legislative actions.

Recommendation – DHS-IME should work to execute 28E agreements with UIHC and BMC, as required by the *Code*.

FINDING R - Transfer from the IowaCare account

On July 23, 2008, $2,000,000 was transferred from the IowaCare account to the General Fund for Medicaid. According to section 249J.24 of the *Code of Iowa*, funds in the

IowaCare account are not to be "transferred, used, obligated, appropriated or otherwise encumbered, except for the purposes of this chapter." The transfer was made to ensure funds were available in the General Fund to pay Medicaid claims. According to DHS personnel, on July 25, 2008, the calculated draw of matching federal funds for IowaCare was supplemented with $2,000,000 from the regular Medicaid draw to restore the transferred funds to the IowaCare account.

Recommendation – Uses of funds in the IowaCare account should be in accordance with the requirements of the *Code.* Specifically, funds should not be transferred from the IowaCare account to pay General Fund claims.

FINDING S - Accounting Errors

On September 15, 2006, DHS made a $613,089.55 entry to the IowaCare account to carry-forward premium collections to the next fiscal year. However, the entry was erroneously coded to federal revenues. The error was not identified until September 15, 2007. In addition, DHS did not timely draw eligible federal funds to the IowaCare account during fiscal year 2006. However, the eligible funds were drawn during fiscal year 2007 and carried-back to fiscal year 2006.

Recommendation – DHS should review all accounting entries for accuracy. In addition, federal revenues should be drawn timely. Also, DHS should review procedures to determine if adequate controls are in place to timely identify erroneous and untimely postings.

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