Department of HUMAN SERVICES

Improve Iowans' Health Status

Medical Assistance
Iowa Health and Wellness Plan
Children's Health Insurance Program
Medical Contracts
State Supplementary Assistance

Medical Assistance
Medicaid – Title XIX

PURPOSE

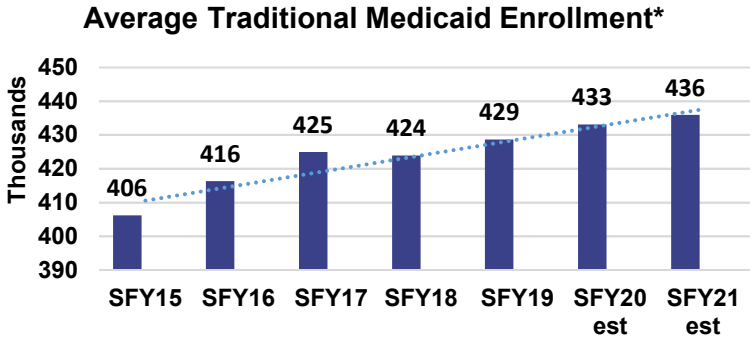
Medical Assistance (Medicaid – Title XIX) provides medically necessary health care coverage for financially needy adults, children, parents with children, people with disabilities, elderly people and pregnant women. The goal is for members to live healthy, stable and self-sufficient lives.

The Department implemented the IA Health Link managed care program for the majority of the Medicaid population on April 1, 2016. Most Medicaid members are now being served by two managed care organizations (MCOs); AmeriGroup and Iowa Total Care. The Iowa Medicaid Enterprise (IME) continues to operate a limited Fee-For-Service (FSS) program for the Medicaid members not enrolled in managed care.

DHS has contracted with MCOs to provide comprehensive health care services including physical health, pharmacy, behavioral health, and long term supports and services. This single system of care promotes the delivery of efficient, coordinated and high quality health care and established accountability in health care coordination.

WHO IS HELPED

Medicaid is projected to serve nearly 783,000 Iowans (unduplicated) or 24.9 percent of Iowa's population in SFY20 and over 792,000 (unduplicated) or 25.2 percent of Iowa's population by SFY21.



*Note: Excludes Health and Wellness Plan and State Family Planning program

Medicaid is Iowa's second largest health care payer, processing nearly 32 million claims in SFY19. This is nearly the same number of claims processed during SFY16.

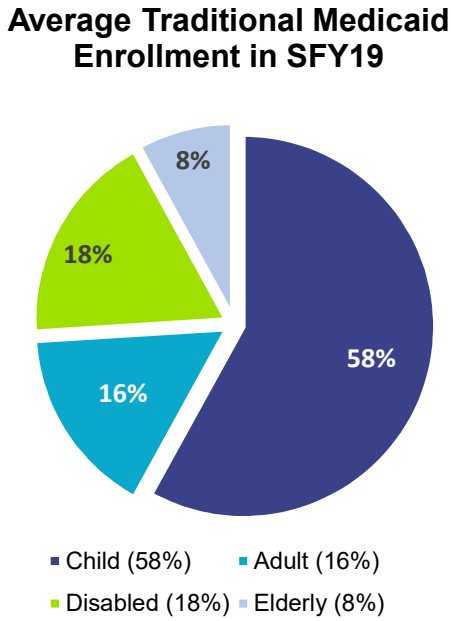
Traditional Medicaid eligibility is based on a combination of income and other criteria that must be met:

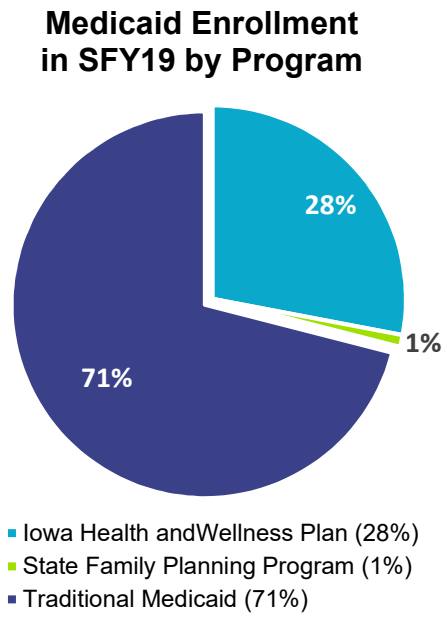
- Members must meet certain income criteria based on multiple eligibility standards and be a U.S. citizen or a legal qualified non-citizen. Citizenship status is verified through the Social Security Administration and legal non-citizens must provide original documentation to verify their status.
- Generally, Medicaid covers low-income members who are aged (over age 65), blind, disabled, pregnant women, children (under 21 years of age) or members of a family with children.
- Medicaid is not available to individuals considered to be inmates of public, non-medical institutions except for inpatient hospital care provided off the grounds of the jail/prison under certain circumstances. Persons who are on probation or are paroled are not considered inmates. Persons who are on work release are considered to be inmates.
- The most common Medicaid member is, on average, a 9-year old child who is very healthy and uses very few health care services apart from well-child care, immunizations, and treatment for common childhood illnesses, such as ear infections. Medicaid covers thousands of such children for very minimal cost.

- Additional populations served include:
    - Individuals with income over 133 percent of the Federal Poverty Level (FPL) through the state-funded family planning program. This program provides very limited covered services.
    - Medicare populations, where Medicaid covers the cost of Medicare premiums, deductibles, and co-payments (Qualified Medicare Beneficiaries).

The Iowa Health and Wellness Plan served more than 169,000 Iowans during SFY19.

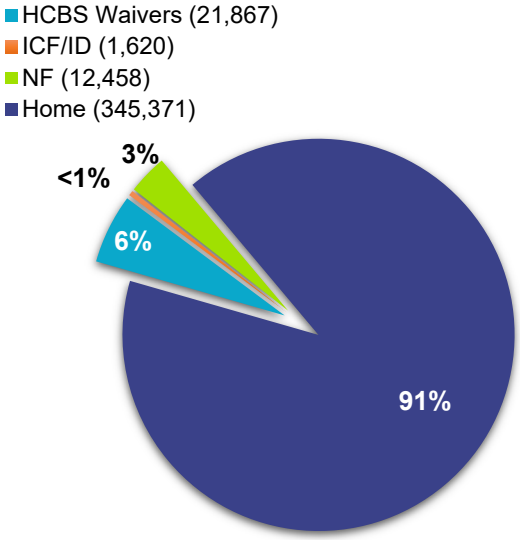
- The Iowa Health and Wellness Plan covers adults ages 19 to 64 with income up to 133 percent of the FPL ($16,612 per year for an individual, and $22,490 for a family of two in 2019).
- Effective August 1, 2017, the Dental Wellness Plan (DWP) was converted into an integrated dental program for all adult Medicaid beneficiaries age 19 and older. The revised DWP incentive structure is designed to improve oral health by encouraging utilization of preventive dental services and compliance with treatment plans. The program has also been modified to remove the earned dental benefit tier structure. Instead, beneficiaries may be required to pay a monthly premium starting in the second year of enrollment.
- DWP beneficiaries are not charged a monthly premium in their second and later years of enrollment in the program if they complete the state-designated Healthy Behaviors in their prior year of enrollment. These Healthy Behaviors include completion of an oral health self-assessment and preventive dental service. DWP beneficiaries owing a monthly premium who fail to pay the monthly premium are eligible for a basic dental benefit package for the duration of the benefit year. At a minimum, the basic dental benefits include the benefits intended to relieve significant pain or relieve acute infection and complete the dental Healthy Behaviors required for waiving premiums.
- In SFY19, the DWP implemented an Annual Benefit Maximum (ABM) of $1,000 per adult member. The ABM is needed for program sustainability, influencing treatment planning, and member accountability. This applies to all populations with the exception of members covered by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Many services are excluded from the ABM including preventive, diagnostic, emergent, anesthesia in conjunction with allowable oral surgery codes, and fabrication of denture benefits.

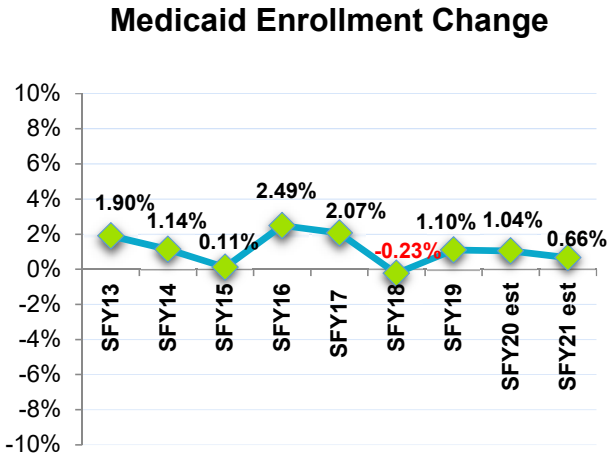


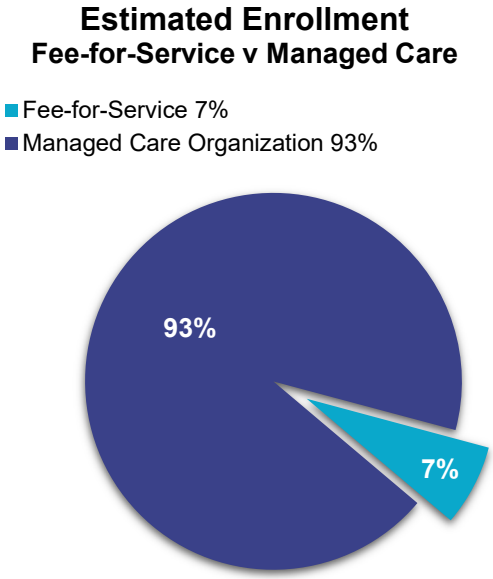


Enrollment growth:

- There were 428,600 members enrolled in traditional Medicaid in SFY19, an increase of 1.1% from SFY18. Excluding the Iowa Health and Wellness Plan, enrollment growth is projected to increase by 1.04% in SFY20 and 0.66% in SFY21.
  - Historically, children have accounted for the majority of the enrollment growth; in recent years, enrollment growth has been more evenly distributed across all categories (child, adult, elderly, and disabled).
- Medicaid plays a key role in the state's child welfare system by funding health care for children in state care. Medicaid provides coverage to children in subsidized adoptive homes, thereby making permanent placement more accessible for children who cannot return to their birth families.







- ✓ *Since SFY10, children have accounted for 64 percent of Medicaid growth.*
- ✓ *Medicaid serves individuals with serious and persistent mental illness (such as schizophrenia or bipolar disorder) and children with serious emotional disturbance. Studies show that individuals living with serious mental illness face an increased risk of having chronic medical conditions. Adults in the U.S. living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions. (www.nami,org/learn-more/mental-health-by-the-numbers)*
- ✓ *Medicaid serves elderly persons who are low-income and very frail. The typical long term care member for older Iowans (65 and older) is a 72-year-old female who needs assistance with at least one activity of daily living, such as personal care.*
- ✓ *Medicaid serves individuals with both physical and/or intellectual disabilities. The typical member with a disability accessing long term care services is a 28-year-old male with an intellectual disability and needs supports with life skills.*
- ✓ *Medicaid members currently have access to the Program for All-Inclusive Care for the Elderly (PACE) in three service areas, covering 16 counties across the state.*

SERVICES

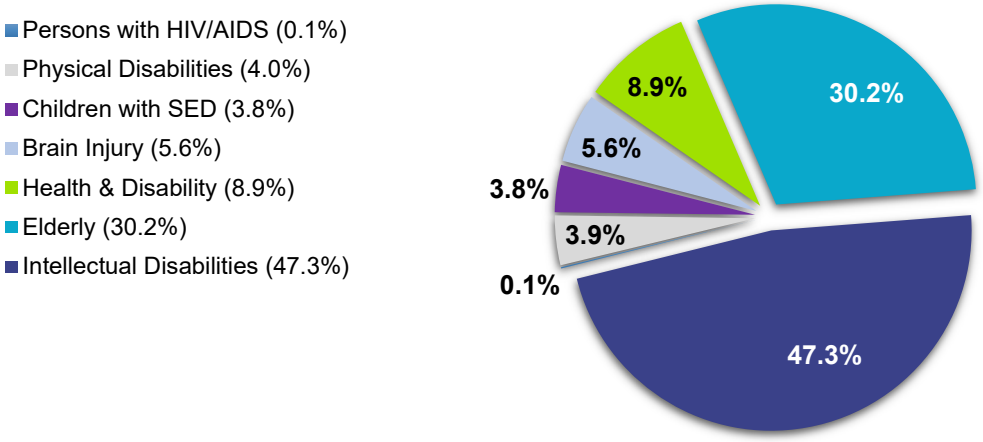
Medicaid covers a comprehensive range of health care services for Iowans who meet the program's eligibility criteria

The majority of members have their services coordinated through a managed care entity, with the exceptions of the Health Insurance Premium Payment (HIPP) program, Medically Needy, PACE enrollees, American Indian/Alaskan natives, and all members that participate in the Medicare Savings Program.

- **Physical Health Care Services** include physician care, hospital services, labs, prescription drugs, home health care, rural health clinic (RHC) services, Federally Qualified Health Centers (FQHCs) services, chiropractic care, physical therapy, and dental care.
- **Behavioral Care Services** include community mental health services, hospital services, physician care, psychiatric medical institution care, outpatient treatment and therapy, rehabilitative mental health services (known as Behavioral Health Intervention Services), as well as non-traditional services such as peer support and Assertive Community Treatment, and substance abuse treatment that can only be delivered through managed care.
- **Long Term Care Services** include Nursing Facilities (NF), Skilled Nursing Facilities (SNF), Nursing Facilities for Individuals with Mental Illness (NF/MI), Intermediate Care Facilities for the Medically Complex (ICF/MC), Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID), and Home and Community Based Services (HCBS) that allows individuals to remain in their homes.
- **Home- and Community-Based Services (HCBS)** are for people with disabilities and older Iowans who need services to allow them to stay in their home and community with services. The programs include HCBS Waivers (there are seven), Habilitation Services, PACE, Home Health, Hospice, Targeted Case Management (TCM), and Money Follows the Person (MFP). These programs include services such as employment, residential, home health, assistance with personal care, homemaking and respite care that are intended to assist members with remaining in their homes and communities.
    - The MFP program funding for services will end March 31, 2021 unless federal legislation is passed to extend funding for the waiver program.
- **HCBS Services** are delivered through seven 1915(c) waivers that are targeted to specific populations including persons who:
    - Are Elderly
    - Have an Intellectual Disability
    - Have a Disability (two waivers)
        - Physical
        - Other Disabilities
    - Are Children with Serious Emotional Disturbance
    - Are Living with HIV/AIDS
    - Have a Brain Injury

- **State Plan HCBS Services** are delivered through the 1915(i) state plan amendment. The HCBS Habilitation program provides service funding and individualized supports to maintain eligible members in their own homes or communities who require assistance due to the functional limitations typically associated with chronic mental illness.

SFY19 Members by HCBS Waiver Type



- ✓ *Based on current managed care capitation rates, the average cost of a member in a nursing facility is $59,825 per year, versus $17,188 for a person served through an HCBS Elderly waiver.*
- ✓ *Based on current managed care capitation rates, the average cost of a member in an Intermediate Care facility for the Intellectually Disabled is $175,630, versus an average cost of $60,738 for a person served through the HCBS ID waiver.*
- ✓ *Medicaid generates 10-20 percent of most hospitals' revenues, but is on average, about 50 percent of nursing facilities' revenue. In the area of services for people with disabilities, Medicaid is often the primary or only revenue source.*

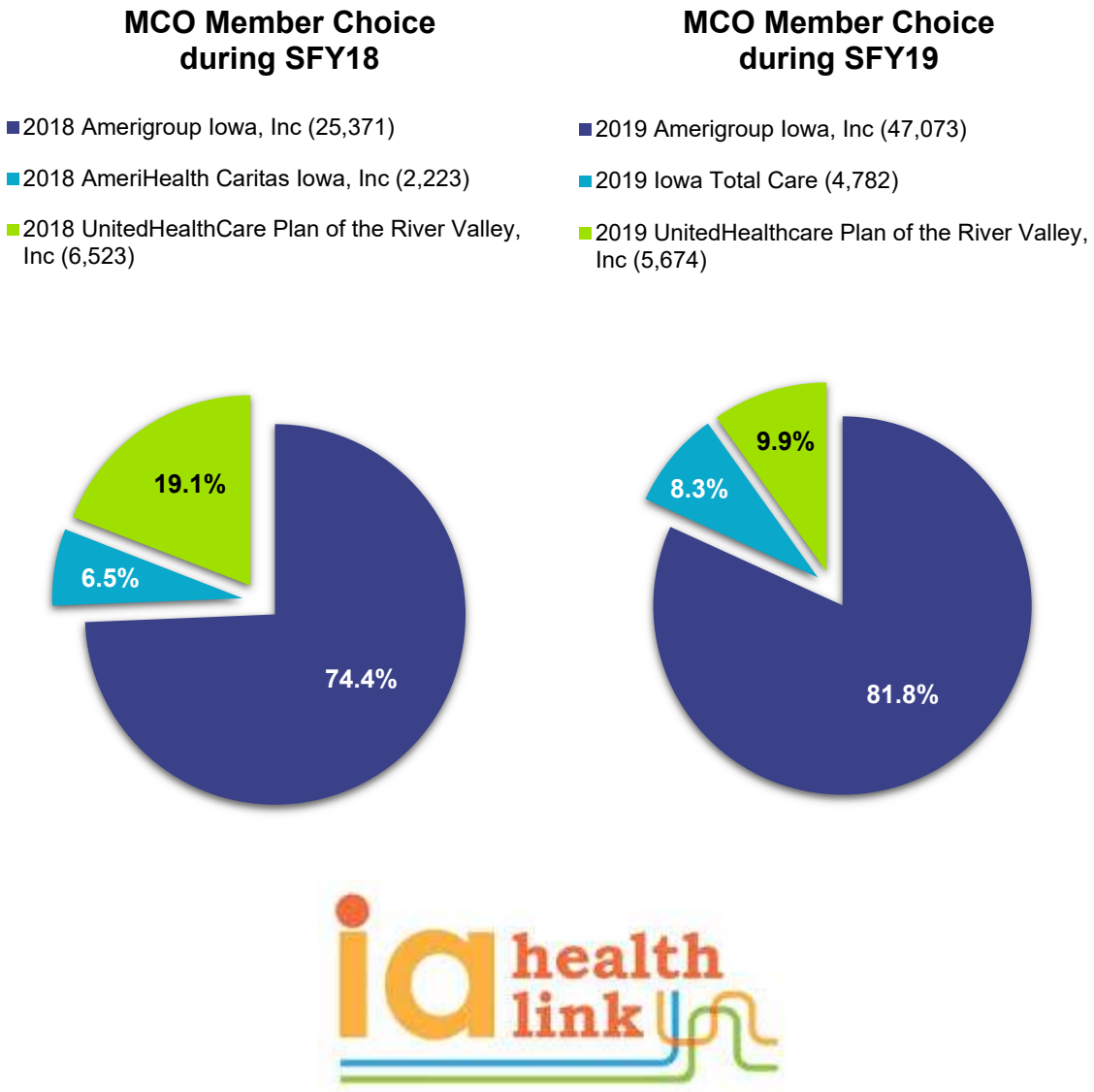
GOALS & STRATEGIES

Under IA Health Link, DHS enrolls the majority of the Medicaid members in MCOs. This comprehensive managed care program provides a single system of care to address health care needs of the whole person. This includes physical health, behavioral health, and long term care services and supports.

Primary goals of IA Health Link include:

- Improved quality and access
- Greater accountability for outcomes
- Greater stability and predictability in the Medicaid budget

Effective July 1, 2019, the IME implemented passive assignment for Medicaid enrollees. Once a member has been deemed eligible for Medicaid, they will be automatically assigned to a MCO. Members are able to receive services from this MCO immediately. Members will have 90 days from their initial enrollment to change MCOs for any reason. If they don't make a choice, they will remain with the MCO assigned to them. This will result in a decrease in the number of Fee-for-Service enrollees.



On December 16, 2014, the U.S. Department of Health and Human Services announced that Iowa was a State Innovation Model (SIM) grantee to test if value-oriented healthcare reforms could produce superior results when implemented in the context of a state-sponsored plan.

The four-year grant of $43 million was wrapped into Iowa's managed care approach via specific requirements, including Value Based Purchasing (VBP) and the use of Health Risk Assessments (HRA) including questions identifying Social Determinants of Health (SDoH). SDoH are key drivers of poor health outcomes and cost, but addressing these social factors means that payment models and member support systems need substantial change.

The resources provided through the Iowa SIM grant were used to align and transform Iowa's statewide delivery system to perform not only on individual patient care, but also accountable for population health outcomes. Through the SIM, Iowa focused on two primary drivers: aligning payers in VBP and equipping providers to understand and deliver improved population health outcomes. Together, these drivers aimed toward a statewide, healthcare transformation vision where providers are paid on value and communities and health systems work together to produce healthier people, creating a system that is affordable and sustainable.

Medicaid implemented an aligned set of VBP contract requirements during the final year of the grant, and began the process of moving future VBP strategy into the existing Medicaid Quality Committee framework. Statewide VBP strategy across Medicare, Medicaid and commercial plans continued increasing the number of covered lives and advancing overall maturity relative to the national Health Care Payment Learning & Action Network (HCP-LAN) standard. Within the state's Medicaid systems modernization effort (called the MEME project), the stage is set to realize the analytic competence necessary to support VBP in a sustainable way through Medicaid moving ahead.

While the funded period of the grant concluded on April 30, 2019, the SIM has been a key mechanism for new conversations, procedures and partnerships to establish and achieve multi-sector goals supporting the overall health of Iowa. The Governor's Healthcare Innovation and Visioning Roundtable will continue to build on what the SIM grant started in its vision for the future: Iowans will experience better health and have access to accountable and affordable healthcare in every community. While the grant is complete, the improvements move ahead and the Department of Human Services is a lead agency in this important public-private partnership.

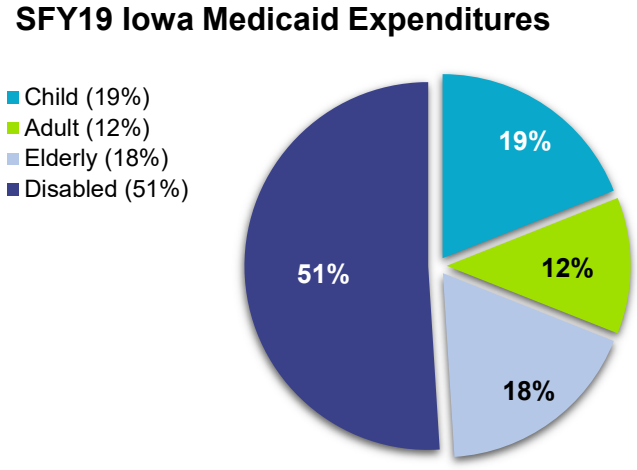
- ✓ *Medicaid collected over $153 million in revenue through cost avoidance and recovery when other insurance is present in SFY19.*
- ✓ *Medicaid achieved savings and cost avoidance of $10.4 million (state and federal) through the identification of overpayments, coding errors, and fraud and abuse in Fee-For-Service (FFS) claims during SFY19.*

COST OF SERVICE

Costs vary widely. 58 percent of traditional Medicaid members are children, but they account for only 19 percent of costs. Conversely, 18 percent of members are people with disabilities, but they account for 51 percent of Medicaid expenses.

- The average annual cost for Medicaid services provided to a member was $9,440 in SFY19 (all funds). Medicaid has a large number of healthy children with a low cost of $3,079, and a small number of very costly elderly and disabled persons with an average cost of $24,319.
- Members with chronic disease drive a significant share of Medicaid costs. Five percent of members account for 48 percent of acute care costs.
- Many of these high-cost members are also 'dual eligibles' (members who are eligible for both Medicare and Medicaid). More than half of dual eligibles are adults with a Serious Mental Illness; 70,000 dual eligibles cost more than $1 billion.

Long term care costs account for nearly half of Medicaid spending such as nursing facilities, home and community based supports, and services for persons with disabilities. Many individuals could be served in less expensive home and community based settings.

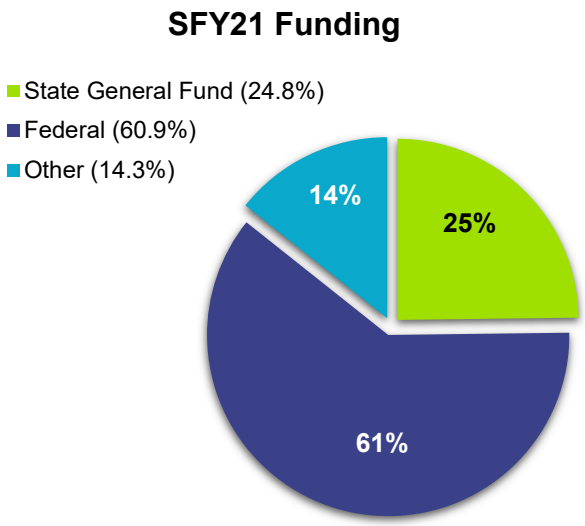


FUNDING SOURCES

Medicaid is funded by state general funds, other state funds, and federal matching funds through the Federal Medical Assistance Percentage (FMAP).

The current budget for SFY21 is $6.25 billion:

- $1.55 billion (24.8 percent) is state general fund.
- $3.80 billion (60.9 percent) is federal funding.
- $893.1 million (14.3 percent) is other funding including drug rebates and other recoveries, Health Care Trust Fund (tobacco tax), and nursing facility and hospital assessment fee revenue.



SFY21 BUDGET DRIVERS

The total SFY21 Medical Assistance budget request reflects a $124,702,167 (8.7 percent) general fund increase from the SFY20 Enacted Appropriation.

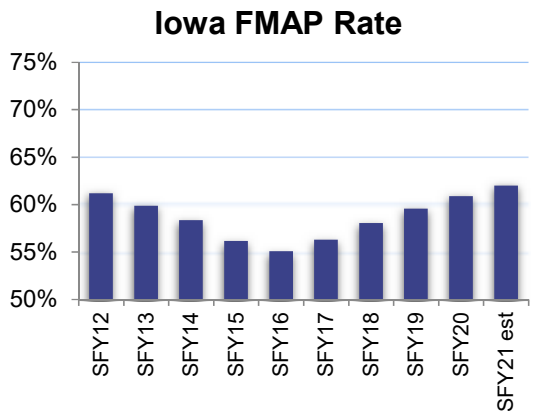
The SFY21 request does not include funding for MCO capitation rate changes, nursing facility rebasing, hospital rebasing, the home health low utilization payment adjustment (LUPA) rate update, or increases in inpatient psychiatric reimbursement rates.

Key factors impacting the SFY21 Medical Assistance budget request increase include:

- Phase-down of the Iowa Health and Wellness Plan Newly Eligible FMAP ($13.4 million)
- Prior year unfunded need ($106.6 million)
    - SFY20 MCO rate increase ($67.8 million)
    - End of session shortfall ($9.1 million)
    - State revenue changes ($7.9 million)
        - Primarily Health Care Trust Fund / Tobacco Tax
    - Lower drug rebates and other recoveries ($17.3 million)
    - Other changes ($4.4 million)
- Other state revenue changes ($2.5 million)
- Anticipated growth in enrollment and costs ($21.6 million)
- Payment of calendar year 2020 health insurer fee ($26.4 million)
- Additional mental health funding ($3.8 million)
- These are offset by an increase in regular Medicaid FMAP rate which decreases the need for state funds ($50.2 million)

The FMAP rate (federal share) has been increasing since SFY17.

- SFY12: 61.19 percent
- SFY13: 59.87 percent
- SFY14: 58.35 percent
- SFY15: 56.14 percent
- SFY16: 55.07 percent
- SFY17: 56.28 percent
- SFY18: 58.05 percent
- SFY19: 59.57 percent
- SFY20: 60.88 percent
- SFY21: 61.99 percent (estimated)



- ✓ *More than $109 million of the SFY21 projected expenditure increase is due to an anticipated unfunded need in SFY20 and state revenue losses.*
- ✓ *The phase-down of the Iowa Health and Wellness Plan Newly Eligible FMAP results in a revenue decrease of $13.4 million in SFY21.*

PROGRAM REVISION TO BENEFIT IOWANS:

The IME consistently monitors federal initiatives and best practices to identify possible program revisions. Considerations cover a broad range of program areas and may include for example, IME administrative operations, administrative improvements for providers or members, health care best practice improvement or changes in reimbursement methodologies.

Revisions are assessed for overall value and benefit for Iowa. When revisions are under consideration, discussions occur with a variety of stakeholder groups including the Medical Assistance Advisory Council (MAAC), Mental Health Disability Service (MHDS) regions, provider workgroups, etc. Revisions are also shared with the DHS Council for their consideration and input.

Revisions considered over the past year include:

- Quarterly training instead of annual training as well as more provider specific training
- Improved access to Hepatitis C medication.
- Bringing uniformity to Iowa Medicaid processes to reduce the administrative burden on provider sand improve access for members.
- Technology solutions that will benefit our members and providers. For example, the IME is currently updating the “Click-Pay” functionality for member payment of premiums and exploring portal solutions for members and providers.
- Robust data analytics to assist in the development and monitoring population health including the addition of social determinants of health information.
- Converting all providers to electronic billing which improves the claims to payment time.

The Governor recommended and the 2018 and 2019 General Assembly passed legislation requiring increased access to mental health services for adults with complex mental health service needs and children needing mental health services. The Department’s Medicaid request includes funding for:

- Increased Assertive Community Treatment reimbursement rates to the low estimate needed for sustainable funding identified by the Department’s legislatively required 2018 report.
- Estimated costs for increased access to Medicaid mental health treatment and crisis services for children.

LEGAL BASIS

Federal:

- Title XIX of the Social Security Act
- 42 CFR 440. 42 CFR 440.210 and 42 CFR 440.220

State:

- Iowa Code Chapter 249A further defines the services and eligibility categories the Iowa Medicaid Program is required to cover. This offer maintains statutorily required services and populations.

Request - Medical Assistance
State Fiscal Year 2021

Request Total: $6,245,657,534 **General Fund Need:** $1,551,453,842

Request Description:

This request maintains current Iowa Medicaid eligibility standards, and provides those services mandated by Title XIX for all eligible individuals. This request also provides all State Plan services which are not "mandatory" under Title XIX but which are medically necessary and currently covered by Iowa Medicaid.

This request provides funding for the Iowa Health and Wellness Plan. Beginning January 1, 2014, the Iowa Health and Wellness Plan will cover all Iowans ages 19-64 with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The plan will provide a comprehensive benefit package and provider network, along with important program innovations that will improve health outcomes and lower costs. The new plan serves many former IowaCare enrollees. The majority of program costs will be funded with 100% federal funds through calendar year 2016. This enhanced federal match rate will be 95% in 2017 and gradually decline to 90% by 2020, where it will remain permanently. A small portion of enrollees will receive regular federal match rates because they were previously eligible for other full benefit Medicaid eligibility groups.

Funding for the Health Insurance Premium Payment (HIPP) program is also included. The purpose of the HIPP program is to reduce Medicaid costs by obtaining health insurance for Medicaid-eligible people. Section 4402 of the Omnibus Budget Reconciliation Act (OBRA) permits states to pay the cost of enrolling an eligible Medicaid recipient in an employer group health insurance plan when it is determined cost-effective to do so. Medicaid program costs are reduced by establishing or maintaining a third-party resource as the primary payer of the recipient's medical expenses. This is particularly true for persons who may not otherwise enroll in an available health insurance plan or who may drop health insurance once Medicaid eligibility is attained.

SFY20 Enacted Appropriation - 2019 Session

SFY20 Enacted Appropriation	$1,427,379,707
SFY20 OCIO Appropriation Adjustment	$1,968
Total State $ Appropriated:	$1,427,381,675

Funding Needed to Maintain Current Service Level

Decision Package	Decision Package Description	Amount
1	**Prior Year Unfunded Need -** The SFY20 unfunded need for obligations continuing in SFY21.	$106,562,335
2	**State Revenue Changes** - Lower Health Care Trust Fund revenue ($1,400,000), Palo Tax revenue ($602,080) and Decatogerization revenue ($500,000).	$2,502,080
3	**MCO Payments** - Includes less than a one percent trend in member months.	$10,200,906
4	**Health Insurer Fee** - Payment of the calendar year 2020 health insurer fee in SFY21. The fee was suspended in 2019.	$26,357,024
5	**Non-MCO Expenditures** - Increases in fee-for-service claims, Medicare Part A and B premium payments and the Medicare Part D Clawback payment.	$15,609,295
6	**Expenditure Offsets** - Increases in drug rebates and other recoveries (third party liability, estate recovery, etc.).	($4,248,028)
7	**Additional Mental Health Funding** - Increases related to expansion of the Adult and Children's Mental Health programs.	$2,969,867
8	**Proposed Legislative Changes -** Provide a reimbursement rate increase for Assertive Community Treatment providers consistent with the low end estimate included in the December 2018 Assertive Community Treatment Reimbursement Rates Report.	$870,933
9	**FMAP Change -** Increase in the regular FMAP from 60.88 percent to an estimated 61.99 percent generates state savings of $50.2 million. This is offset by a decrease in the Health and Wellness Plan newly eligible FMAP rate from 91.5 percent to 90.0 percent which increased state costs of $13.4 million.	($36,752,244)
	Total Requested for Current Service Level Funding:	$124,072,167

Note
The SFY21 request does not include funding for MCO capitation rate changes, nursing facility rebasing, hospital rebasing, or the home health low utilization payment adjustment (LUPA) rate update.

Request - Medical Assistance
State Fiscal Year 2021

General Fund Total	$1,551,453,842

General Fund Change From Prior Year	$124,072,167

Total Funding Summary:

State Funding Total	$1,843,821,874

	Program
General Fund	$1,551,453,842
Health Care Trust Fund	$199,200,000
Quality Assurance Trust Fund	$58,570,397
Hospital Health Care Access Trust Fund	$33,920,554
Other*	$677,081
Total	$1,843,821,874

* Other: Palo Tax, Medicaid Fraud Fund, and Decategorization reversion.

Federal Funding Total	$3,801,137,605

	Program
Temporary Assistance to Needy Families (TANF)	$0
Social Services Block Grant (SSBG)	$0
Federal Financial Participation (FFP)	$3,801,137,605
Other**	$0
Total	$3,801,137,605

** Other:

Other Funding Total	$600,698,054

	Program
Other***	$600,698,054

***Other: Includes intergovernmental transfers, rebates and recoveries, state resource centers, and school-based services.

Totals	Program	Request Total
	$6,245,657,534	$6,245,657,534

FTEs included in request:

FTEs	11.0

Iowa Health and Wellness Plan

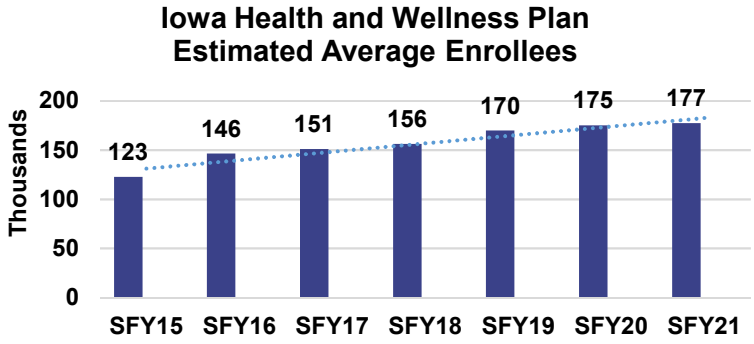
PURPOSE

The Iowa Health and Wellness Plan covers all Iowans, ages 19-64, with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The plan provides a comprehensive medical and dental benefit package, along with important program innovations, that aim to improve health outcomes and lower costs.

The Department implemented the IA Health Link managed care program for the majority of the Medicaid population on April 1, 2016. Most Medicaid members are now being served by two managed care organizations (MCOs); AmeriGroup and Iowa Total Care. The Iowa Medicaid Enterprise (IME) continues to operate a limited Fee-For-Service (FSS) program for the Medicaid members not enrolled in managed care.

WHO IS HELPED

The Iowa Health and Wellness Plan expands access to health care coverage for low-income adults.



The plan covers adults, ages 19-64 who are not otherwise eligible for comprehensive Medicaid or Medicare:

- Persons with incomes 0-100 percent of FPL (up to $12,490 for a family of one and up to $16,910 for a family of two).
- Persons with incomes between 101 percent and 133 percent of FPL ($12,491-$16,612 for a family of one and $16,911-$22,491 for a family of two).

✓ *During SFY19, the Iowa Health and Wellness Plan served an average of 154,972 individuals that were not previously covered by a full benefit Medicaid plan.*

SERVICES

The Iowa Health and Wellness Plan provides health care to thousands of adults who would otherwise may not have access to any type of healthcare regardless of income.

- The plan offers innovations and reform in the delivery of health care services through leverging care coordination models.
- The plan provides a comprehensive benefit package that ensures coverage for all of the Essential Health Benefits (EHB) as required by the Affordable Care Act (ACA).
- Comprehensive health services, equivalent to the State Employee Health Benefit Package.
- Robust provider network focused on primary care to assist in the coordination of health services and assist members with completing healthy behaviors.

Eligibility for Long Term Services and Supports

- The Iowa Wellness Plan will not cover Long Term Services and Supports (LTSS). Individuals who need LTSS, including 1915(i) habilitation services, will be considered medically frail and will default to coverage through the State Plan. Medically frail individuals may opt-out of the State Plan into the Iowa Wellness Plan but will not receive LTSS services as a wrap-around if they do so.

Covered Benefits

- Ambulatory patient services (e.g. Physician Services)
- Emergency Services
- Hospitalization
- Mental health and substance use disorder services, including behavioral health treatment
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Prescription drugs equivalent to the Medicaid benefit
- Preventive dental services and treatment equivalent to the Medicaid benefit

✓ *During SFY19, the Dental Wellness Plan enrolled an average of 56,464 individuals with an average of 178,983 members enrolled with a dental claims administrator.*

GOALS & STRATEGIES

Under IA Health Link, DHS enrolls the majority of the Iowa Health and Wellness Plan members in MCOs. This initiative creates a single system of care to address health care needs of the whole person. Primary goals of the initiative include:

- Improved quality and access
- Greater accountability for outcomes
- Greater stability and predictability in the Iowa Health and Wellness Plan budget

Strategies of the Iowa Health and Wellness Plan designed to improve Iowans' health status includes:

- Collecting data on social determinants of health and patient confidence, through the use of health risk assessments.
- Implementing a new delivery system and payment model to promote improved care management, care coordination, and health care quality.
- Implementing a unique incentive plan to encourage development of cost-conscious consumer behavior in the consumption of health care services.

The Dental Wellness Plan (DWP) is designed to improve the delivery of dental services.

Key program criteria includes:

- Increased access to care
- Member accountability
- Increased utilization of preventive services
- Continuity of care
- Improved outcomes for members
- Financial sustainability

Enrollees will have access to full dental benefits during their first year of enrollment. To maintain access to these full benefits in their second year of enrollment without a premium obligation, enrollees must complete the required Healthy Behaviors during their first enrollment year. These Healthy Behaviors include:

- Completion of an oral health self-assessment, and;
- Preventive dental service

Enrollees over 50 percent of the FPL who have not completed the DWP Healthy Behavior in their first year of program enrollment will be charged a monthly dental premium of $3 beginning in their second year of enrollment. Enrollees with a premium obligation who fail to make ongoing monthly premium payments will be eligible for basic dental benefits only. At a minimum, basic benefits include emergency benefits are to relieve signifcant pain or relieve acute infection.

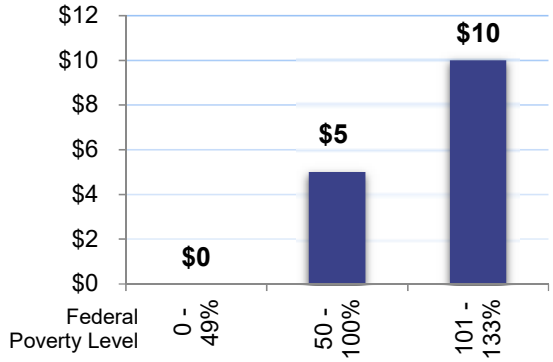
Annual completion of the required Healthy Behaviors will waive an enrollee's premium for the following year. Therefore, members who continue to complete the required Healthy Behaviors will never be subject to a monthly premium.

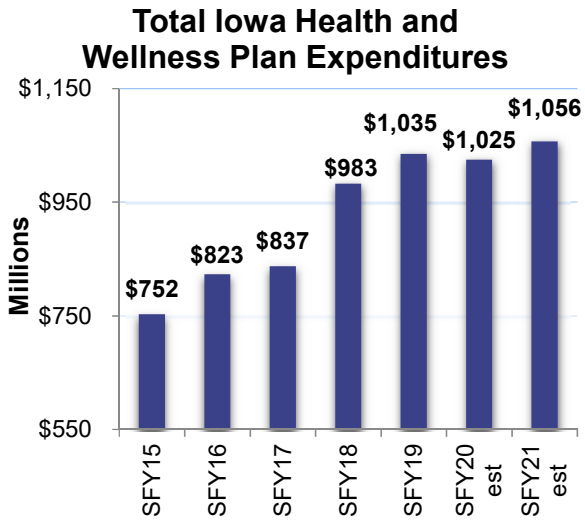
In SFY19, DWP implemented an Annual Benefit Maximum (ABM) of $1,000 per adult member. The ABM is needed for program sustainability, influencing treatment planning, and member accountability. This applies to all populations with the exception of members covered by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Many services are excluded from the ABM including preventive, diagnositc, emergent, anesthesia in conjunction with allowable oral surgery codes, and fabrication of denture benefits.

COST OF SERVICE

Participant financial contribution under the Iowa Health and Wellness Plan medical benefit has innovative features designed to encourage utilization of preventive care and overall health promotion and disease prevention through an incentive-based program.

- No co-payments, except $8 for using the emergency room when it is not a medical emergency.
- No monthly contributions or premiums in the first year.
- No contributions after the first year if the member completes preventive services and/or wellness activities.
- Monthly contributions only for adults with incomes at 50 percent or greater of the FPL if preventive services/wellness activities not completed.
- Iowa Health and Wellness Plan member may claim a hardship exemption indicating that payment of the monthly contribution will be a financial hardship.



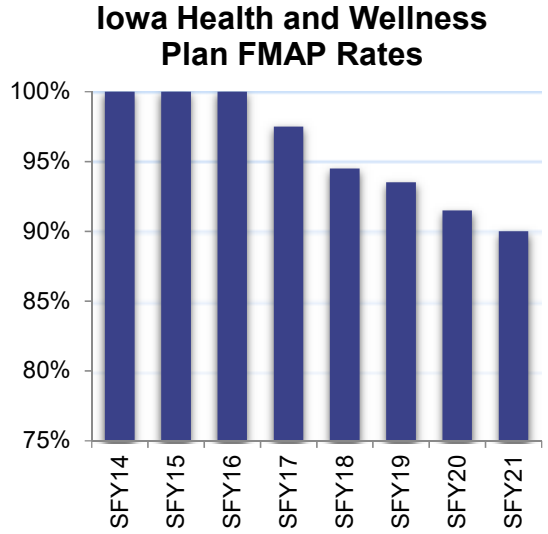


- ✓ *Out of pocket costs can never exceed 5 percent of household income.*
- ✓ *The program incentivizes members to engage in health and wellness activities in order to have their monthly premiums waived.*
- ✓ *Enrollees who continue to complete health improvement behaviors in each 12-month period of enrollment will not be subject to the required monthly financial contribution.*

FUNDING SOURCES

- The vast majority of Health and Wellness Plan costs are reimbursed at the enhanced Federal Medical Assistance percentage (FMAP) for the New Adult Group under the ACA.
- A small portion of enrollees will receive regular federal match rates because they were previously eligible for other full benefit Medicaid eligibility groups.
- Administrative costs have match rates of 50%, 75%, or 90% depending on the type of expenditure.

SFY21 BUDGET DRIVERS



PROGRAM REVISION TO BENEFIT IOWANS:

The IME consistently monitors federal initiatives and best practices to identify possible program revisions. Considerations cover a broad range of program areas and may include for example, IME administrative operations, administrative improvements for providers or members, health care best practice improvement or changes in reimbursement methodologies.

Revisions are assessed for overall value and benefit for Iowa. When revisions are under consideration, discussions occur with a variety of stakeholder groups including the MAAC, MHDS regions, provider workgroups, etc. Revisions are also shared with the DHS Council for their consideration and input.

Revisions considered over the past year include:

- Bringing uniformity to Iowa Medicaid processes to reduce the administrative burden on provider sand improve access for members.
- Technology solutions that will benefit our members and providers. For example, the IME is currently updating the “Click-Pay” functionality for member payment of premiums and exploring portal solutions for members and providers.
- Robust data analytics to assist in the development and monitoring population health including the addition of social determinants of health information.
- Improved access to Hepatitis C medication.
- Converting all providers to electronic billing which improves the claims to payment time.
- Quarterly training instead of annual training as well as more provider specific training

The Governor recommended and the 2018 and 2019 General Assembly passed legislation requiring increased access to mental health services for adults with complex mental health service needs and children needing mental health services. The Department's Medicaid request includes funding for:

- Increased Assertive Community Treatment reimbursement rates to the low estimate needed for sustainable funding identified by the Department's legislatively required 2018 report.
- Estimated costs for increased access to Medicaid mental health treatment and crisis services for children.

LEGAL BASIS

The Iowa Health and Wellness Plan operates under an 1115 demonstration waiver and under a 1915b managed care waiver. The IHWP benefits are identified in the State Plan for alternative benefits.

Federal:

- Section 1115 of the Social Security Act; Section 1902(a) (10) (B); Section 1902(a) (13) and (a) (30); Section 1902(a) (14); 1902(a) (23) (A); Section 1902(a)(4); Section 1902(a)(1); Section 1902(a) (34); Section 1902(a) (54).

State:

- Iowa Senate File 446

Children's Health Insurance Program

Healthy and Well Kids in Iowa (Hawki) and Hawki Dental-Only

PURPOSE

The Children's Health Insurance Program (CHIP) provides health care coverage for children and families whose family income is too high to qualify for Medicaid but too low to afford individual or work-provided health care. The purpose of CHIP is to increase the number of children with health and dental care coverage, thereby improving their health and dental outcomes.

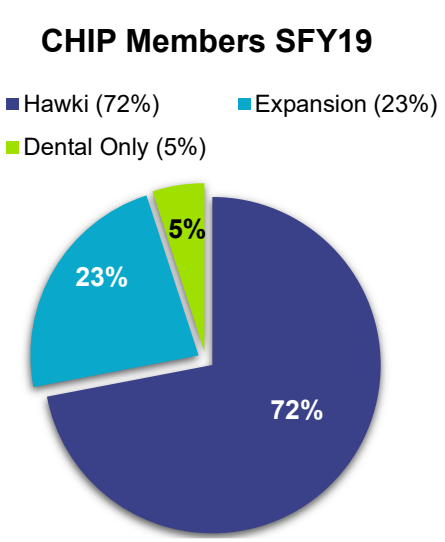
The Department implemented the IA Health Link managed care program for the majority of the Medicaid population on April 1, 2016. Most Medicaid members are now being served by two managed care organizations (MCOs); AmeriGroup and Iowa Total Care. The Iowa Medicaid Enterprise (IME) continues to operate a limited Fee-For-Service (FSS) program for the Medicaid members not enrolled in managed care.

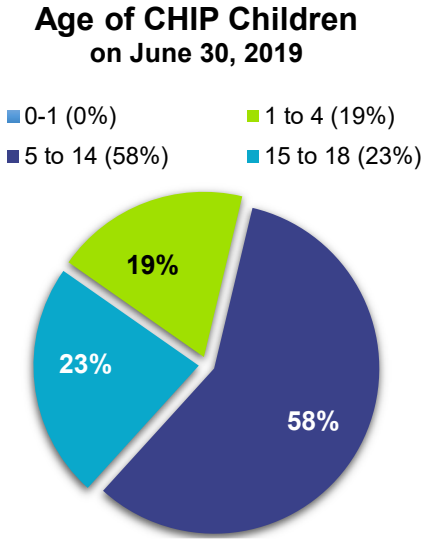
WHO IS HELPED

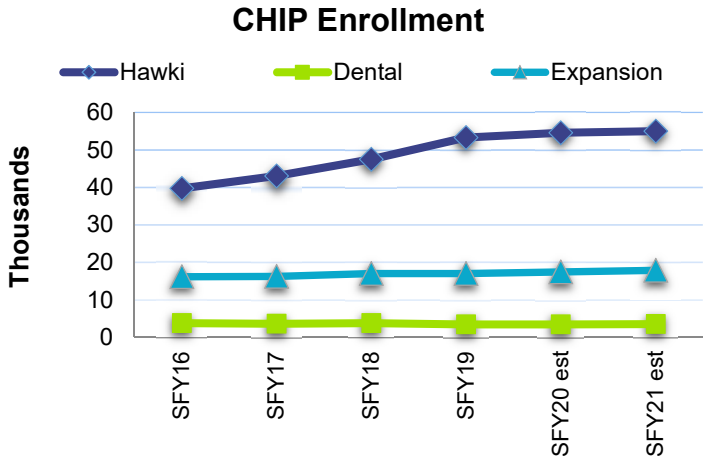
Enrollment in Iowa's CHIP program has been instrumental in providing coverage to thousands of uninsured children since 1998, and Iowa has historically been among the states with the lowest uninsured rate among children.

CHIP has three parts: a Medicaid expansion, a separate program called Hawki, and a dental-only plan.

- Medicaid expansion provides coverage to children ages 6-18 whose family income is between 122 and 167 percent of the Federal Poverty Level (FPL), and infants whose family income is between 240 and 375 percent of the FPL.
- The Hawki program provides coverage to children under age 19 in families whose family income is between 168 percent and 302 percent of the FPL based on Modified Adjusted Gross Income (MAGI) methodology.
- Total CHIP enrollment increased by 8 percent (5,494 enrollees) in SFY19. Enrollment is projected to increase by 2.4 percent (1,772 enrollees) in SFY20 and 1.3 percent (959 enrollees) in SFY21. Projected increases are based on historical enrollment.







- ✓ *In SFY19, an average of 17,076 children were covered in the Medicaid expansion program; 53,270 in* Hawki*; and 3,450 in the dental-only plan.*
- ✓ *Enrollment in the CHIP program increased to 73,797 in SFY19, and is expected to increase to 75,569 children in SFY20, and to 76,528 children in SFY21.*
- ✓ *A comprehensive outreach campaign includes producing publications, free-and-reduced lunch mailings, statewide grassroots outreach, and by giving presentations to various groups who can assist with enrolling uninsured children in the Hawki program. $32,466 in state money was budgeted for SFY19.*

SERVICES

The CHIP program is administered under Title XXI of the Social Security Act and covers a comprehensive range of health and dental services for Iowa's children who meet the program's eligibility criteria.

CHIP program members receive services through an MCO. Today, Amerigroup Iowa Inc. and Iowa Total Care are the MCOs serving the CHIP program.

Key components of the CHIP program are:

- Children covered by the Medicaid expansion receive full Medicaid coverage through MCOs. This activity receives enhanced federal funding through Title XXI, rather than Title XIX.
- Hawki coverage is similar to commercial health care coverage and includes, but is not limited to, doctor visits, inpatient and outpatient hospital, well-child visits, immunizations, emergency care, prescription medicines, eye glasses and vision exams, dental care and exams, speech, occupational, and physical therapy, ambulance, and mental health and substance abuse care covered through managed care.
- Required dental coverage includes diagnostic and preventive services, routine and restorative services, endodontic and periodontal services, cast restorations, prosthetics and medically necessary orthodontia.

- ✓ *Iowa is one of only a limited number of states with CMS-approved dental plans which include basic dental coverage and medically necessary orthodontic coverage.*
- ✓ *The covered services under Hawki are different from traditional Medicaid and are approximately equivalent to the benefit package of the state's largest Health Management Organization (HMO) at the time the program was initiated.*

GOALS & STRATEGIES

CHIP and Hawki members are enrolled in MCOs. This comprehensive managed care program provides a single system of care to address health care needs of the whole person. Primary goals of IA Health Link include:

- Improved quality and access
- Greater accountability for outcomes
- Greater stability and predictability in the CHIP and Hawki budget

COST OF SERVICE

CHIP is projected to cover 76,523 children in SFY20 at a total (federal and state) program cost of $158.9 million.

- Families pay a monthly premium of $10-$20 per child with a maximum of $40 per family based on family income.
- The SFY19 total annual cost per member for Medicaid expansion children is $2,509.
- The SFY19 total annual cost per member for Hawki children enrolled with the health plan is $1,895. This cost represents the premiums paid to health plans.
- The SFY19 average annual cost for children in dental only program is $343.

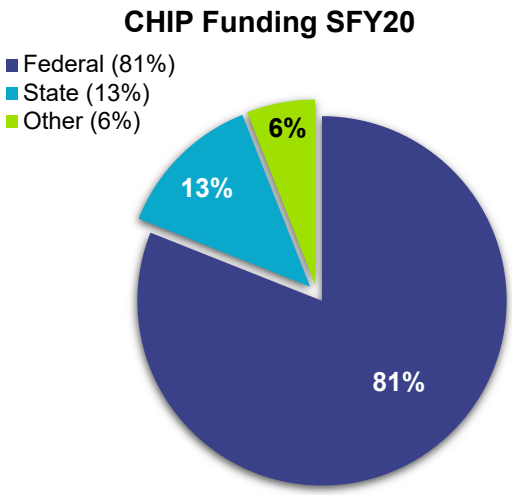
✓ *When all costs for administration and services are included, the average total annual cost per person in the CHIP program is projected to be $1,982 in SFY19.*

✓ *The SFY19 total annual cost of administering the CHIP program (including the Third Party Administrator, claims processing, outreach, and state staffing) was $6.0 million.*

FUNDING SOURCES

The CHIP program is authorized and funded through Title XXI of the Social Security Act. Funding is authorized through September 30, 2023. This budget request assumes the program continues in its current form in SFY21.

- The SFY20 appropriation amount is $19,361,112.
- In SFY20, the state will pay a match rate of 13.00 percent, and in SFY21, the state will pay a match rate of 23.72 percent.
- Approximately $10.4 million in revenue from enrollee premiums, drug rebates, and other recoveries are projected to be collected in SFY19, $9.6 million in SFY20, and $9.8 million in SFY21.



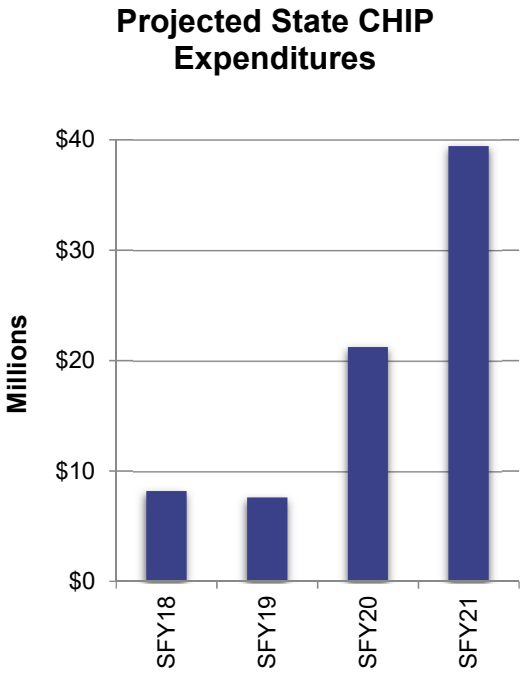
- ✓ *The reauthorization of the CHIP program included a change, gradually reducing the enhanced Family Medical Assistance Percentage (FMAP) rate beginning in SFY20. The federal CHIP rate will decrease to 87.00 percent in SFY20 and 76.28 percent in SFY21.*
- ✓ *Federal funding for CHIP is authorized to end September 30, 2023.*

SFY21 BUDGET DRIVERS

The total SFY21 CHIP budget request reflects a $20.0 million (103.5 percent) increase over the SFY20 Enacted Appropriation.

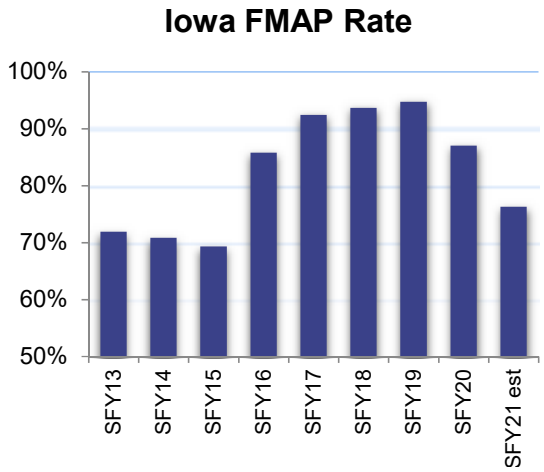
- The CHIP federal match rate is expected to decrease from 87.00 percent in SFY20 to 76.28 percent in SFY21 (estimated). This results in an increased need for state funding of $17.6 million in SFY21.
- Total CHIP enrollment is projected to increase by 1.3 percent in SFY21. This increase represents 959 new enrollees.
- Due to enrollment increases, revenue from enrollee premiums is projected to increase 1.0 percent in SFY21.

Though the CHIP program was reauthorized through September 30, 2023, the enhanced FMAP rates offered through the program are being phased out in SFY20 and SFY21. The result is a significant increase in need for additional state funding as noted above.



Iowa's CHIP FMAP rate by fiscal year is provided below.

- SFY13: 71.91 percent
- SFY14: 70.84 percent
- SFY15: 69.30 percent
- SFY16: 85.80 percent
- SFY17: 92.40 percent
- SFY18: 93.64 percent
- SFY19: 94.70 percent
- SFY20: 87.00 percent
- SFY21: 76.28 percent (estimated)



- ✓ *Average CHIP enrollment was 73,797 in SFY19 and is projected to be 75,569 in SFY20 and 76,528 in SFY21.*
- ✓ *Total state annual cost is projected to increase by 103.5 percent in SFY21 over the SFY20 Enacted Appropriation.*

LEGAL BASIS

Federal:

- Title XXI of the Federal Social Security Act. The Affordable Health Care Act (ACA), signed into law on March 23, 2010, continues CHIP programs through September 30, 2023. The ACA prohibits states from reducing their current eligibility standards until this date. Under Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), funding for the program is authorized through September 30, 2023.

State:

- Chapter 514I of the Code of Iowa; 441 IAC Chapter 86

Request - Children's Health Insurance Program
State Fiscal Year 2021

Request Total: $174,335,131 **General Fund Need:** $39,406,326

Request Description:

The Children's Health Insurance Program (CHIP) is authorized under Title XXI of the Social Security Act. Title XXI enables states to provide health and dental care coverage to uninsured, targeted low-income children. Targeted low-income children are those children covered by Medicaid (M-CHIP) or a separate program called the Healthy and Well Kids in Iowa (Hawki) program. The M-CHIP component covers children ages 6 to 18 years of age whose countable family income is between 122 percent and 167 percent of the federal poverty level (FPL) and infants between 240 percent and 375 percent of the FPL. The Hawki program provides health and dental care coverage to children under the age of 19, whose countable family income is between 168 percent and 302 percent of the FPL, and who are not eligible for Medicaid and are not covered under a group health plan or other insurance.

The Hawki program also provides a Dental-only plan to children under the age of 19 whose countable family income is less than or equal to 302 percent of the FPL and who are not eligible for Medicaid. Children who are covered under an individual or group health or dental plan eligible for the Hawki Dental-only plan.

SFY20 Enacted Appropriation - 2019 Session

SFY20 Enacted Appropriation	$19,361,112
SFY20 OCIO Appropriation Adjustment	$20
Total State $ Appropriated:	$19,361,132

Funding Needed to Maintain Current Service Level

Decision Package	Decision Package Description	Amount
1	**Prior Year Unfunded Need -** The SFY20 unfunded need for obligations continuing in SFY21.	$1,244,831
2	**State Revenue Changes -** Replacement of carry-forward available in SFY20, but not available in SFY21.	$513,190
3	**MCO Payments -** Enrollment growth estimate of 1.3%.	$219,806
4	**Administrative Spending -** Assumption of 3% increase in administrative spending.	$14,442
5	**Health Insurer Fee -** Payment of the calendar year 2020 health insurer fee in SFY21. The fee was suspended in 2019.	$444,086
6	**FMAP Change -** 23% enhanced FMAP completely eliminated in FFY21.	$17,608,839
	Total Requested for Current Service Level Funding:	$20,045,194

General Fund Total	**$39,406,326**

General Fund Change From Prior Year	**$20,045,194**

Request - Children's Health Insurance Program
State Fiscal Year 2021

Total Funding Summary:

State Funding Total	**$39,406,326**

	Program
General Fund	$39,406,326
Health Care Trust Fund	$0
Quality Assurance Trust Fund	$0
Hospital Health Care Access Trust Fund	$0
Other*	$0
Total	$39,406,326

* Other:

Federal Funding Total	**$124,962,224**

	Program
Temporary Assistance to Needy Families (TANF)	$0
Social Services Block Grant (SSBG)	$0
Federal Financial Participation (FFP)	$124,962,224
Other**	$0
Total	$124,962,224

** Other:

Other Funding Total	**$9,966,582**

	Program
Other***	$9,966,582

***Other: Rebates, recoveries, and member premiums.

Totals	**Program**	**Request Total**
	$174,335,131	**$174,335,131**

FTEs included in request:

FTEs	-

Medical Contracts

PURPOSE

The Department implemented the IA Health Link managed care program for the majority of the Medicaid population on April 1, 2016. Most Medicaid members are now being served by two managed care organizations (MCOs); AmeriGroup and Iowa Total Care. The Iowa Medicaid Enterprise (IME) continues to operate a limited Fee-For-Service (FSS) program for the Medicaid members not enrolled in managed care.

Medical contracts include those contracts that enable IME, as the federally designated single state Medicaid agency, to operate the FFS program, oversee the MCOs, and conduct operations required for the overall Medicaid program. To carry out these functions, the IME has 57 full-time state employees, including 10 Health Insurance Premium Payment (HIPP) staff; this total includes 2 vacant HIPP and 4 vacant Medicaid positions. There are 8 performance based contracts with vendors which serve as the primary support to IME staff for both the MCO and FFS programs. With the implementation of managed care, other specialized vendors have been added. In addition to these contracts, the IME has a host of contracts with other state agencies and entities to provide services and activities to support Medicaid, Hawki and Iowa Health and Wellness Plan members.

WHO IS HELPED

Vendors enable the IME to operate the state Medicaid and Hawki programs. Medicaid membership fluctuates, and it generally serves around 650,000 members through the various programs. About 575,000 to 600,000 members are served in managed care and from 40,000 to 70,000 are served in the FFS program.

The Department implemented an MCO passive assignment process beginning July 1, 2019. Passive assignment means the State assigns and enrolls members into a managed care plan without offering an “up front” plan selection period. This is often referred to an “auto-assignment process”. Once assigned, the member will have opportunities to change plans. This process removes the FFS period prior to the members being enrolled in managed care.

SERVICES

IME has a total of 33 contracts (not including MCO, Dental, or Non-Emergency Medical Transportation). The following are the primary contracts pertaining to FFS and managed care and the remaining contracts are with a variety of agencies to provide related services:

External Quality Review Organization (EQRO) carries out review and quality assurance functions required by Centers for Medicare and Medicaid Services (CMS). These functions are designed to assure the integrity of the managed care program operations.

Core Services processes all FFS claims, processes MCO capitation rates, operates systems including the Medicaid Management Information System (MMIS) and manages the mailroom operations.

Quality Improvement Organization (QIO) provides clinical support such as performs all initial Level of Care (LOC) decisions for waiver and institutional care; approves MCO recommended LOC changes and all FFS LOC reviews, provides utilization management and quality assurance for the FFS members and carries out quality assurance for both the FFS and the managed care programs.

Member Services is the State’s Medicaid Managed Care enrollment broker. It provides customer services to the FFS population and provides assistance to members seeking issue resolution with the MCOs.

Actuarial Contract establishes the managed care capitation rates and assists in the review of expenditures data.

Pharmacy Services maintains the Preferred Drug List (PDL) that applies to all Medicaid members. In addition, this vendor processes prior authorization (PA) requests and answers the Pharmacy Hotline for FFS members. The vendor also collects drug rebates from manufacturers and responds to pharmacy provider questions and processes FFS pharmacy claims.

Program Integrity (PI) performs provider audits and recoveries of improper payments, identifies potential fraud, waste and abuse and make referrals to law enforcement for investigations and prosecutions. PI also coordinates with other units within the Department, the Attorney General's Office, Dental Benefit Managers (DBMs), Medicaid Fraud Control Unit (MFCU), MCOs and other federal/state agencies to promote payment and program integrity. PI provides oversight of the Dental Benefits and Managed Care Entities fraud, waste and abuse programs and improper payment recoveries. In addition, PI assists in validating managed care data.

Provider Cost Audit (PCA) and Rate Setting perform rate setting, cost settlement and cost audit functions and technical assistance to both providers and MCOs. Provider rates serve as the rate floor for MCOs unless otherwise negotiated.

Provider Services enrolls all Medicaid providers including FFS and managed care. Provider Services provides direct support to providers in the FFS programs and coordinates with the MCOs to provide training to providers. In addition, Provider Services gives assistance to providers seeking issue resolution with the MCOs.

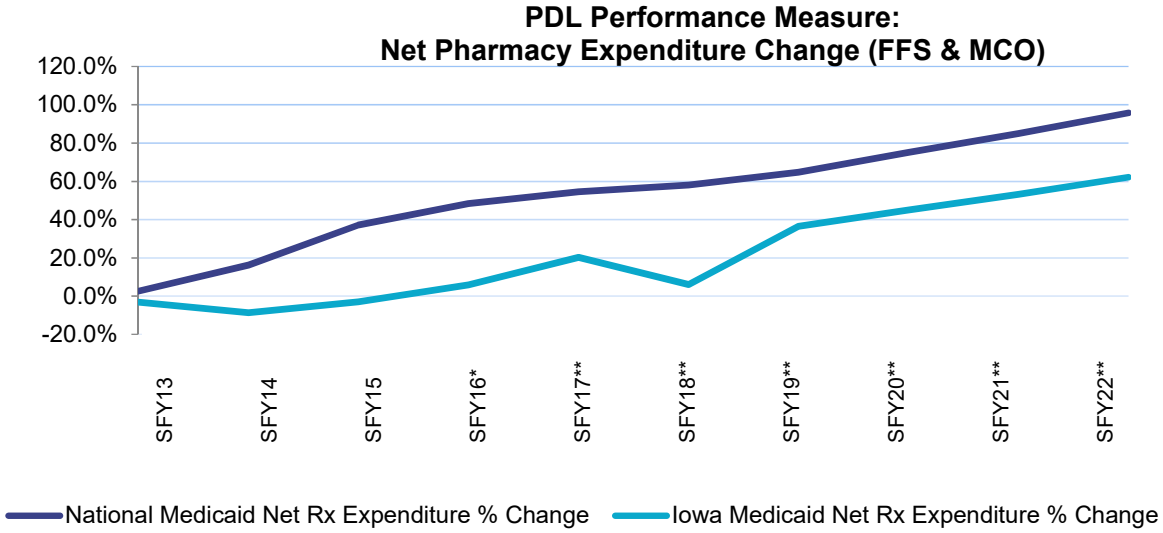
Revenue Collections carries out Third Party Liability (TPL) functions for the FFS members and estate recovery for all members.

- ✓ *Medicaid processed over 21.5 FFS million claims in SFY18, and over 31.7 million FFS claims in SFY19. The average time from the receipt of an electronic claim form to payment was nine days in SFY18, compared to nearly six days in SFY19.*
- ✓ *PI saved Medicaid $10.4 million in SFY19 through the identification and recoveries of improper payments, outstanding overpayments, and fraud, waste and abuse.*
- ✓ *The MCOs are expected to be at least as efficient at recovery of inappropriate Medicaid payments as Iowa Medicaid was in FFS.*

GOALS & STRATEGIES

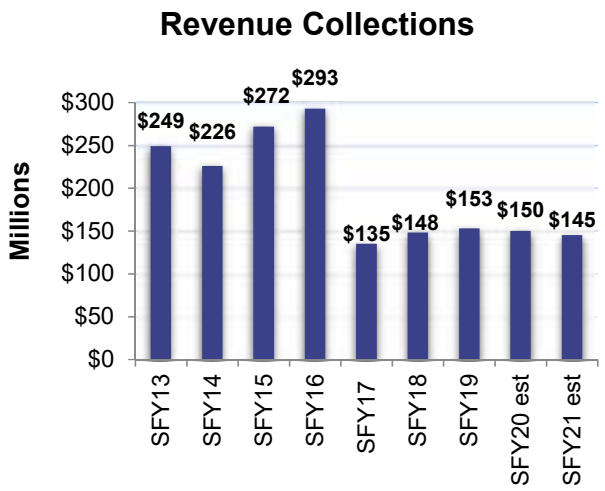
By modernizing the Medicaid program, the IA Health Link initiative aim is to:

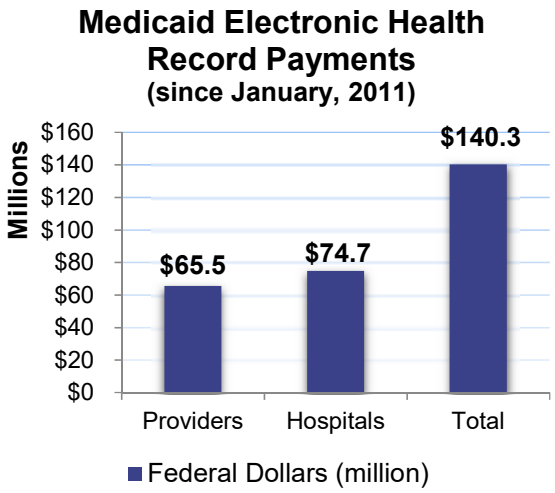
- Improve quality and access
- Promote accountability for outcomes
- Create a more predictable and sustainable Medicaid budget



*Projected for National Medicaid Net Rx Expenditure Change

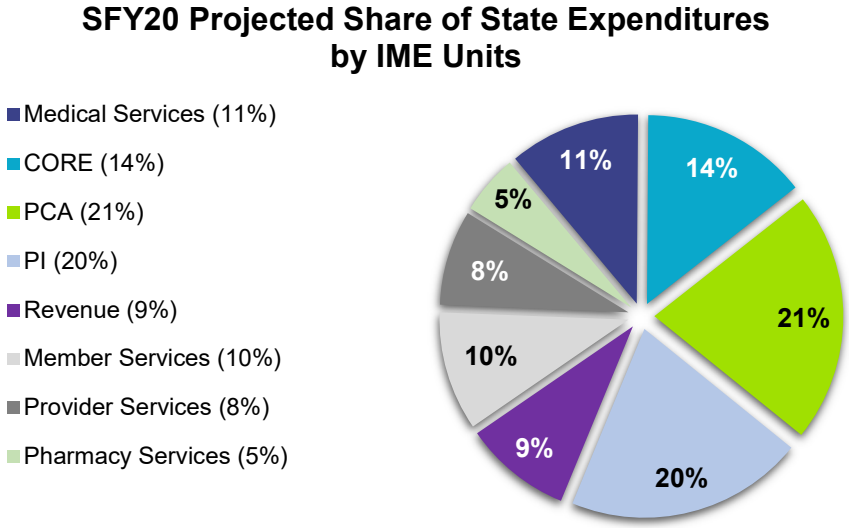
**Projected for both National Medicaid Net Rx Expenditure and Iowa Medicaid Net Rx Expenditure Changes





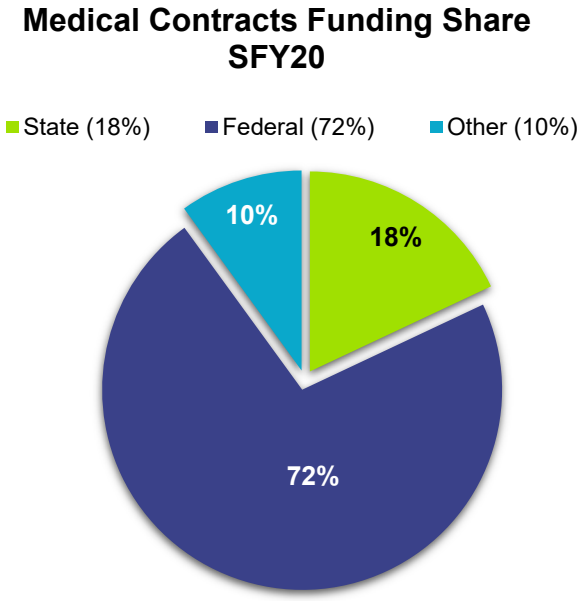
COST OF SERVICE

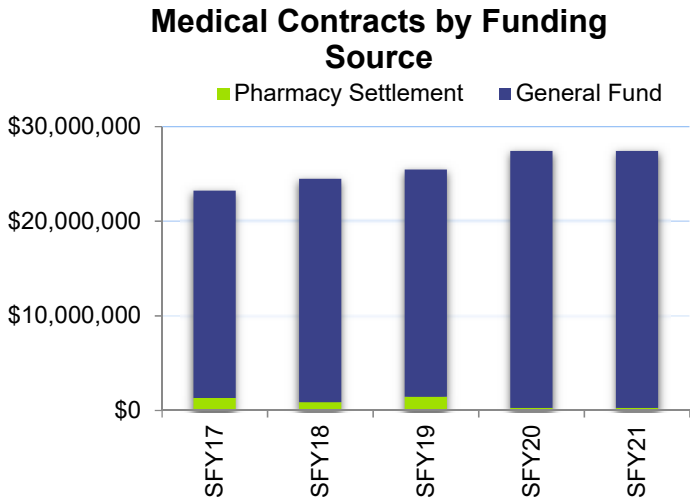
- Medicaid administrative costs go toward managing the program, processing claims, managing member usage of services, provider and member assistance, rate setting, and recovering funds from other payors or providers.

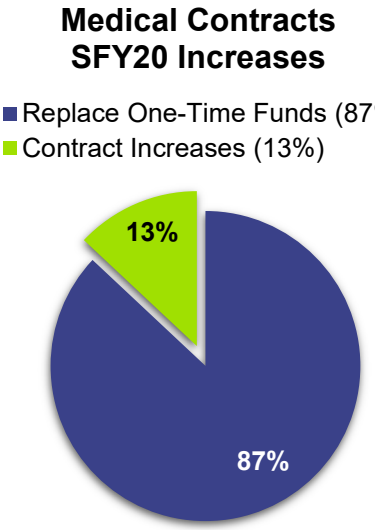


FUNDING SOURCES

- The IME Medical Contracts are funded with state and matching federal funds.
- The state share of funding varies for each contract ranging from 10 percent (e.g. system development), 25 percent (e.g. CORE, Medical Services, and Pharmacy POS) to 50 percent for others (e.g. Revenue Collections, PCA).
- The federal matching rate is determined by the makeup of vendor personnel and activities performed.







LEGAL BASIS

Federal:

Title XIX of the Social Security Act. 42 CFR 434.1. Section 1902(a) (4) of the Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan. 434.1(b) sets forth the requirements for contracts with certain organizations for furnishing Medicaid services or processing or paying Medicaid claims or enhancing the agency's capability for effective administration of the program.

State Supplementary Assistance

PURPOSE

State Supplementary Assistance (SSA) helps low-income elderly or disabled Iowans meet basic needs and reduces state spending for Medicaid.

WHO IS HELPED

SSA eligibility criteria include:

- Requirements about disability or age as defined by Social Security standards.
- Receipt or eligibility to receive Supplemental Security Income (SSI).
- Citizenship and residency.
- Limitations on income and assets.

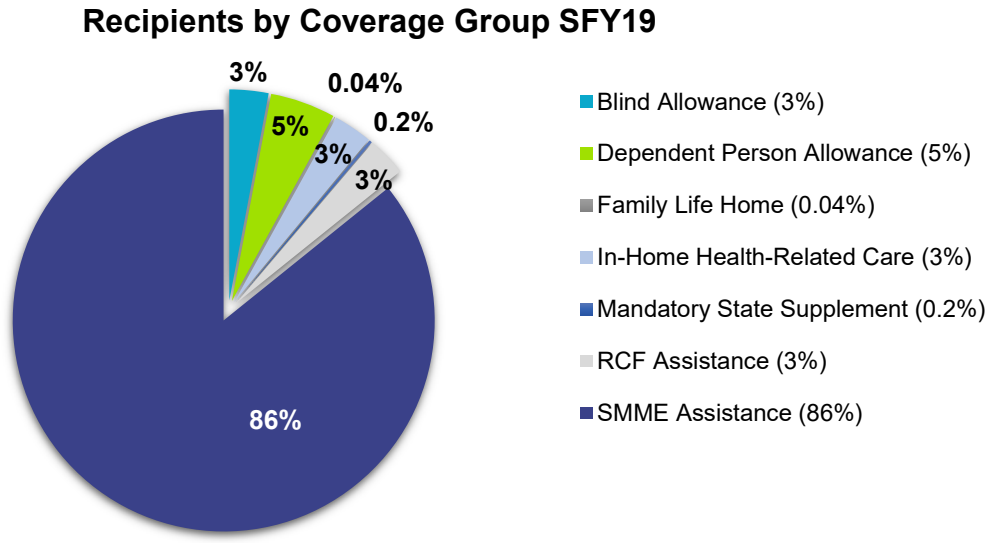
There are seven SSA groups.

Approximately 86 percent of SSA recipients are in the Supplement for Medicare and Medicaid Eligible (SMME) group. While providing a $1 monthly payment to the person, it saves the state money that would otherwise be paid by the state for the recipients' Medicare Part B premiums.

In SFY19 an average of 17,018 cases received an SSA benefit. A case may be a single person or a couple if living together.

Examples of the monthly income requirements:

- Residential Care Facility (RCF), monthly income of $1,072 or less.
- In-Home Health-Related Care (IHHRC), monthly income of $1,251 or less.
- Blind, monthly income of $793 or less.



May not equal 100% due to rounding.

✓ *In addition to receiving SSA, most recipients also receive Medicaid.*

SERVICES

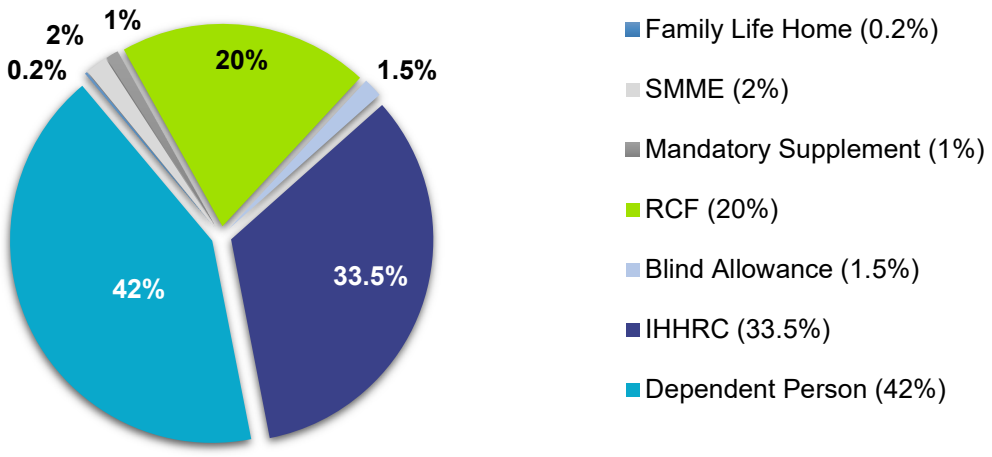
State Supplementary payments provide cash payments to help meet basic needs.

Individuals receiving In-Home Health-Related Care, Residential Care Facility, and Family Life Home services help pay for the cost of their care through an assessed client participation amount. SSA pays the difference between the actual cost of care and the client participation amount.

Monthly benefits:

- Dependent Person Allowance, up to $398.
- In-Home Health-Related Care, up to $480.
- Blind Allowance, up to $22.
- Mandatory Supplement, an average of $185.
- Supplement for Medicare and Medicaid Eligible, $1 per month.
- Residential Care Facility assistance, up to $1,072.
- Family Life Home Payment, up to $142.

Expenditures by Coverage Groups in SFY19



May not equal 100% due to rounding.

- ✓ *Most SSA payment types must meet a minimum payment amount set by the federal government. States can pay more but not less. Iowa is at the federal minimum for all but IHHRC.*
- ✓ *RCF and Dependent Person payment levels are affected by Social Security cost of living allowance increases. The payments must increase each January to equal the increased federal minimum payments.*

GOALS & STRATEGIES

Goal: Provide Access to Health Care Services

Strategies:

- Access federal dollars for payment of Medicare Part B premiums for more Medicaid members through the SMME coverage group.
- Continue to provide assistance in the least restrictive setting for elderly and disabled recipients.

Results in SFY19:

- The number of SMME participants increased slightly during SFY19, maintaining the amount the state pays for the Medicare Part B premiums for those individuals.

✓ *SSA supplements the SSI program for people with a financial need that is not met.*

COST OF SERVICE

The average cost of providing SSA varies greatly between coverage groups, ranging from $12 annually for SMME Assistance to $5,443 for persons receiving In-Home Health-Related Care Assistance.

FUNDING SOURCES

The total budget for SFY20 is $8,365,584.

$8,350,584 (99.8 percent) of funding is from the state general fund; $15,000 (0.2 percent) is from other funds.

✓ *State Supplementary Assistance is funded 100 percent with state dollars and used to meet the Medicaid federal Maintenance of Effort (MOE) requirement.*

✓ *Failure to fully fund the SSA program puts the state at risk of losing federal funding for the state's Medicaid program as the result of not meeting Medicaid MOE requirements.*

✓ *There was a 2.8 percent Social Security COLA in CY2019. In July 2019, the Annual Social Security Trustee Report projected a COLA of 1.8 percent for CY2020, 2.6 percent for CY2021, and 2.6 percent for CY2022. Actual COLAs are typically announced in the late fall and may be different from the Trustee's report.*

LEGAL BASIS

Federal:

- SSA benefits are an MOE requirement for the Medicaid program
- Code of Federal Regulations: 20 CFR 416.2095 and 416.2096

State:

- Iowa Code Chapter 249
- Iowa Administrative Code 441 IAC Chapters, 50-54 and 177