STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

IOWA HEALTH AND WELLNESS PLAN
Section 1115 Demonstration Extension Fast Track Application Supporting Documentation

PROJECT #11-W-00289/8
March 18, 2024

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Table of Contents

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Appendix A: Historical Summary

INITIAL WAIVER APPROVAL: 2014 – 2016

In 2013, the Iowa Legislature passed with bi-partisan support the Iowa Health and Wellness Plan (IHAWP) to provide access to healthcare for uninsured, low-income Iowans, using a benefit design intended to improve health outcomes for beneficiaries. The IHAWP design sought to improve outcomes, increase personal responsibility, and ultimately lower costs. Key goals were to ensure the IHAWP population had access to high-quality local provider networks and modern benefits that worked to improve health outcomes; and to drive healthcare system transformation by encouraging a shift to value-based payments that align with important developments in both the private insurance and Medicare markets.

The IHAWP sought to provide a comprehensive, commercial-like benefit plan that ensures provision of the Essential Health Benefits, indexed to the State Employee Plan benefits, with supplemental dental benefits similar to those provided on the Medicaid State Plan. Through a unique incentive program, the IHAWP also sought to promote responsible health care decisions by coupling a monthly required financial contribution with an incentive plan for members to actively seek preventive health services to earn an exemption from the monthly contribution requirement. Original IHAWP options included the following:

1. The Iowa Wellness Plan (IWP), which covered adults ages 19 to 64, with household incomes at or below 100% of the Federal Poverty Level (FPL); and
2. The Marketplace Choice Plan (MPC), which covered adults ages 19 to 64, with household incomes of 101% through 133% of FPL.

On December 10, 2013, the Centers for Medicare and Medicaid Services (CMS) approved the Iowa Wellness Plan §1115 Demonstration Waiver (Project #11-W-00289) and the Marketplace Choice §1115 Demonstration Waiver (Project # 11-W-00288), thereby enabling the State to implement the IHAWP on January 1, 2014.

Iowa Medicaid originally administered the IWP through several delivery systems including independent primary care physicians (PCPs), accountable care organizations (ACOs), and managed care organizations (MCOs). Services provided by independent PCPs and ACOs were provided on a fee-for-service basis, while MCOs were compensated based on capitation.

The MPC Demonstration allowed enrolled members to select from participating commercial health care coverage plans available through the Health Insurance Marketplace. Medicaid paid MPC member premiums and cost sharing to the commercial health plan on behalf of the member, and members had access to the network of local health care providers and hospitals served by the commercial insurance plan. Historically, members could elect to receive coverage through one of two qualified health plans (QHPs); however, there are no longer any QHPs available to serve the population, thereby eliminating coverage options for the MPC Demonstration. These members were subsequently enrolled in the IWP Demonstration, pursuant to the December 2015 amendment noted below.

AMENDMENTS DURING INTIAL WAIVER PERIOD

Several amendments to the IHAWP waivers were approved during the original Demonstration period. On May 1, 2014, CMS approved the State's request to amend both the IWP and MPC Demonstrations to provide tiered dental benefits to all expansion adults in Iowa with incomes up to and including 133% FPL through a prepaid ambulatory health plan (PAHP). This model was designed to promote and encourage healthy preventive care-seeking behaviors among members, and to ensure competitive reimbursement rates for providers and a reduction in administrative barriers. Core dental benefits included basic preventive and diagnostic, emergency, and stabilization services, implemented through the IWP and MPC alternative benefit plans (ABPs), while tiered "Enhanced," and "Enhanced Plus" earned benefits were provided to beneficiaries through the IWP and MPC Demonstrations, based on beneficiary completion of periodic exams.

In addition to the above amendment, CMS twice approved the State's request to extend its waiver of the non-emergency medical transportation (NEMT) benefit from both the IWP and MPC Demonstrations. When CMS originally approved this authority, on January 1, 2014, it was scheduled to sunset on December 31, 2014, with the possibility of extension based on an evaluation of the impact on access to care. Initial experience demonstrated that lack of NEMT services was not significantly impeding IHAWP member access to care. In fact, from January to June 2014, 39% of members received at least one service and over 14% of members completed physical exams in the first eight months, as compared to an annualized figure of 6.5% for Medicaid overall. After reviewing initial data on the impact of the waiver on access, CMS approved an extension of the NEMT waiver through July 31, 2015. Thereafter, CMS and the State established criteria necessary for the State to continue the NEMT waiver beyond July 31, 2015. Specifically, the State agreed to compare survey responses of the IHAWP members to survey responses of persons receiving "traditional" Medicaid benefits through the State Plan. Iowa conducted the analysis and found that the survey responses of the two populations did not have statistically significant differences. In light of those results, CMS approved a second amendment through June 30, 2016.

Additionally, on December 24, 2015, CMS approved the State's request to amend the IWP Demonstration to allow persons with incomes at or below 133% FPL who were previously eligible for the MPC Demonstration to be eligible for the IWP Demonstration. The transition of existing MPC Demonstration members into the IWP Demonstration took place on January 1, 2016, at which time the IWP also became known as the IHAWP. On February 23, 2016, CMS approved the State's request to implement a managed care delivery system for the Demonstration, concurrent with the §1915(b) High Quality Healthcare Initiative Waiver, effective April 1, 2016.

INITIAL WAIVER EXTENSION & AMENDMENTS: 2017 – 2019

On November 23, 2016, the State received approval to extend the IHAWP for an additional three-year period. This initial extension was approved with no program modifications. Subsequently, the State submitted two amendment requests during the renewal period. The first amendment, approved by CMS on July 27, 2017, modified the Dental Wellness Plan (DWP) component of the Demonstration based on analysis of independent evaluation findings and stakeholder feedback. Through this amendment, the State implemented an integrated dental program for Medicaid enrollees aged 19 and over. The redesigned DWP incorporated an innovative incentive structure to improve oral health by encouraging utilization of preventive dental services and compliance with treatment plans. Movement of adult enrollees to the DWP was designed to provide a seamless experience for enrollees and dental providers as individuals

transition through different eligibility categories. Under the modified DWP, incentives were created for enrollees to appropriately utilize preventive dental services and maintain oral health through the elimination of premium requirements for enrollees who complete preventive dental service requirements. An earned benefit structure was maintained; however, the original tiered benefit structure was eliminated to address the concern that few enrollees were eligible for tier two and tier three DWP benefits under the original DWP structure due to enrollee churn. Under the modified earned benefit structure, to maintain comprehensive dental benefits after their first year of enrollment without a premium obligation, enrollees were required to complete State designated "Healthy Behaviors." This structure was intended to create incentives for members to establish a dental home and encourage the receipt of preventive dental services to promote oral health and preventable oral disease conditions. Enrollees over 50% FPL who failed to complete these Healthy Behaviors within their first year of enrollment were required to contribute financially toward their dental health care costs through monthly premium contributions. Failure to make monthly premium payments resulted in the enrollee being eligible for basic dental services only for the remainder of the benefit year.

Additionally, the State received authority in October 2017 to waive the three-month retroactive eligibility period, except for pregnant women and infants under age one. In accordance with House File 653, passed by the Iowa Legislature in 2017, the State implemented a policy whereby an applicant's Medicaid coverage is effective the first day of the month in which the application for Medicaid was filed. The State subsequently notified CMS, in accordance with Iowa Senate File 2418 (2018), of its intent to reinstate the three-month retroactive Medicaid coverage benefit for applicants who are residents of a nursing facility at the time of application. This change became effective for new Medicaid applications filed on or after July 1, 2018.

SECOND WAIVER EXTENSION & AMENDMENTS: 2020 – 2024

On June 20, 2019, the State submitted a renewal application under Section 1115(f) for a five-year extension. CMS granted approval for the renewal on November 15, 2019. In extending the approval period, CMS updated the waiver of retroactive eligibility to exempt children under 19 years of age. No other substantive changes were made to the Demonstration at this time.

The State subsequently submitted an amendment request on February 25, 2021, to provide dental benefits for children under age 19 through PAHPs. Through this delivery system modification, the State sought to ensure access to high-quality benefits for all enrollees through the seamless delivery of dental benefits. Additionally, the change was intended to improve the oral health of enrollees by encouraging engagement in preventive services and compliance with treatment plans. Further, the State sought to encourage enrollee linkage to a dental home. This transition was effectuated July 1, 2021.

In December 2021, the State further modified the DWP through discontinuation of the dental Healthy Behaviors program. With this change, members enrolled in the DWP are no longer required to complete two Healthy Behavior activities annually or pay a monthly dental contribution to receive full dental coverage.

COVID-19 IMPACTS

In accordance with the Family First Coronavirus Response Act (FFCRA), Iowa maintained enrollment of IHAWP enrollees during the COVID-19 public health emergency (PHE). In turn, the Healthy Behaviors and member contribution requirements were not implemented during this time. Prior to the end of the PHE, the Iowa Department of Health and Human Services (HHS) sent notices to all IHAWP enrollees

informing them of the reinstatement of these program features. Enrollees were given a year from the end of the PHE in May 2023 to complete their Healthy Behaviors. Beginning June 1, 2024, IHAWP enrollees who have not completed this requirement in the prior year are assessed premiums upon completion of their annual eligibility recertification.

DEMONSTRATION GOALS

The IHAWP seeks to further the objectives of Title XIX by:

1. Improving enrollee health and wellness through the encouragement of healthy behaviors and use of preventive services.
2. Increasing enrollee engagement and accountability in their health care.
3. Increasing enrollee's access to dental care.

Additionally, the DWP seeks to achieve the following goals related to dental services:

1. Ensure member access to and quality of dental services.
2. Allow for the seamless delivery of services by providers.
3. Improve the oral health of DWP enrollees by encouraging engagement in preventive services and compliance with treatment goals.
4. Encourage linkage to a dental home.

In furtherance of these key goals, the State seeks to extend the Demonstration, including the subgoals tied to each IHAWP policy component, outlined in Table 1, which are contained in the Evaluation Plan and currently operationalized.

Table 1. IHAWP Subgoals

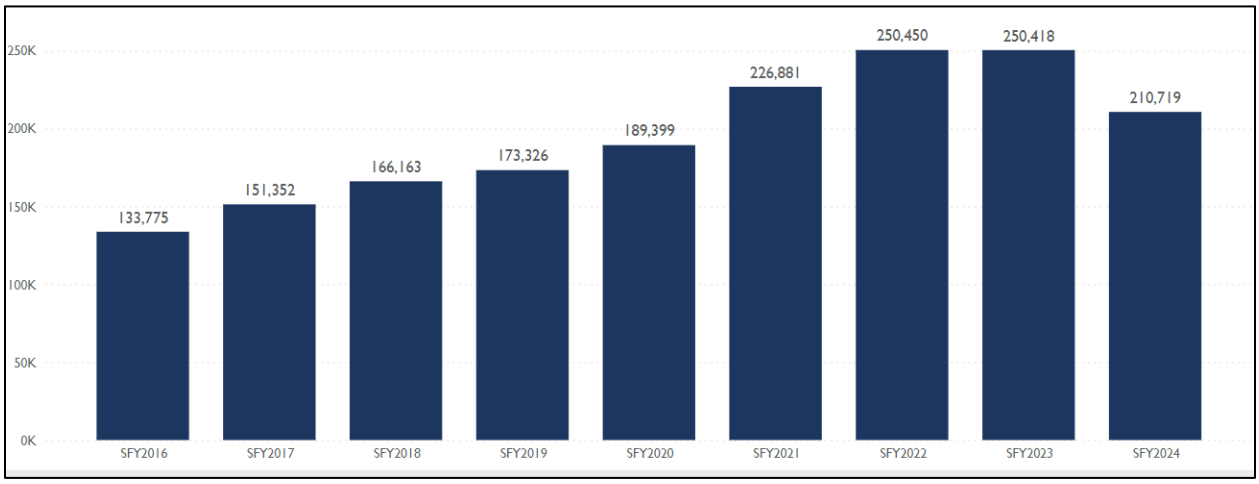
Policy Component	Goals
Healthy Behaviors	1. Empower members to make healthy behavior changes. 2. Begin to integrate health risk assessment (HRA) data with providers for clinical decisions at or near the point of care. 3. Encourage members to take specific proactive steps in managing their own health and provide educational support.
Dental Wellness Plan	1. IHAWP members will have an increase in preventive care use as a result of the Healthy Behaviors requirements.[1] 2. IHAWP members will have increased access to covered services. 3. IHAWP members will experience improved oral health.
Retroactive Eligibility Waiver	1. Encourage members to obtain and maintain health insurance coverage, even when healthy.

[1] Receipt of a dental examination meets the Healthy Behaviors requirement for a preventive visit.

Policy Component	Goals
Cost Sharing (Non-Emergency Use of the Emergency Department Copay)	1. Educate members the emergency department is not the appropriate place for all care. 2. Educate members about the cost of emergency department care. 3. Build relationships with primary care providers improving preventive and chronic care. 4. Increase the availability of emergency departments for those who need them.
Non-Emergency Medical Transportation Waiver	1. To align benefits with those specified by the enabling legislation and make the benefits consistent with those offered by commercial insurers. 2. Help Iowa improve the fiscal sustainability of its Medicaid program, without significant negative effects on beneficiary access to services.
Member Experiences from Increased Healthcare Coverage	1. IHAWP members will have increased access to covered services. 2. IHAWP members will experience consistent, reliable coverage. 3. IHAWP members will experience improved quality of care.

As outlined in Figure 1, since its inception, the IHAWP has expanded access to health care throughout Iowa. Trends in quality measures indicate this coverage has resulted in access to preventive services higher than the national rates, particularly among adults ages 20 - 44. The proposed extension will enable the State to continue its efforts to provide access to otherwise Medicaid ineligible Iowans. This extension request is drafted in accordance with the parameters established by the Iowa legislature to ensure the continued operation of Medicaid expansion within the state. Continuation of the current authorities during the extension term will also permit additional study of Demonstration outcomes which were unavailable during this Demonstration period due to the pause of key IHAWP policies during the PHE.

Figure 1. IHAWP Enrollment SFY 2016 - 2024[2]



[2] SFY 2021 – 2024 enrollment impacted by the COVID-19 PHE.

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Appendix B: Budget Neutrality

CMS has previously determined that the Demonstration is budget neutral based on the assessment that the waiver authorities granted for the Demonstration are unlikely to result in any increase in federal Medicaid expenditures, and that no expenditure authorities are associated with the Demonstration. As documented in the June 24, 2021, CMS approval, it was determined no further test of budget neutrality is required.

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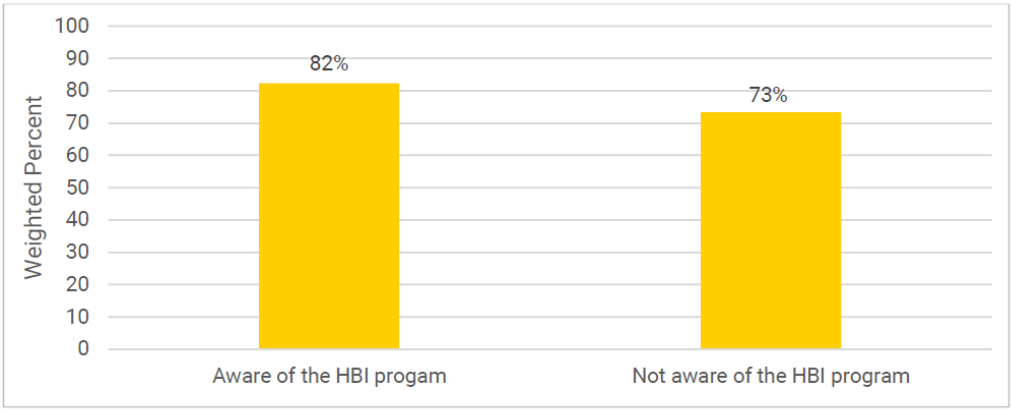
Appendix C: Interim Evaluation

The University of Iowa serves as the independent evaluator for the Demonstration. The Interim Evaluation was completed in accordance with the Demonstration special terms and conditions (STCs) and the evaluation design approved by CMS on June 23, 2021, and subsequently updated on June 23, 2023 to reflect modifications to the DWP. Key findings are highlighted below, and the full Interim Evaluation Report is attached to this submission.

HEALTHY BEHAVIORS[3]

Survey data indicated that those who were enrolled since 2015 have the highest level of awareness of the Healthy Behaviors program at 47%. There is evidence that those who were aware of the Healthy Behaviors program were more likely to complete a wellness exam compared to those who were unaware. Figure 2 shows completion of a wellness exam by awareness of the Healthy Behaviors program. People who were aware of the Healthy Behaviors program were more likely to report having completed a wellness exam (82% versus 73%).

Figure 2. Percent of Respondents Reporting a Wellness Exam by HBI Program Awareness (N=2,832)

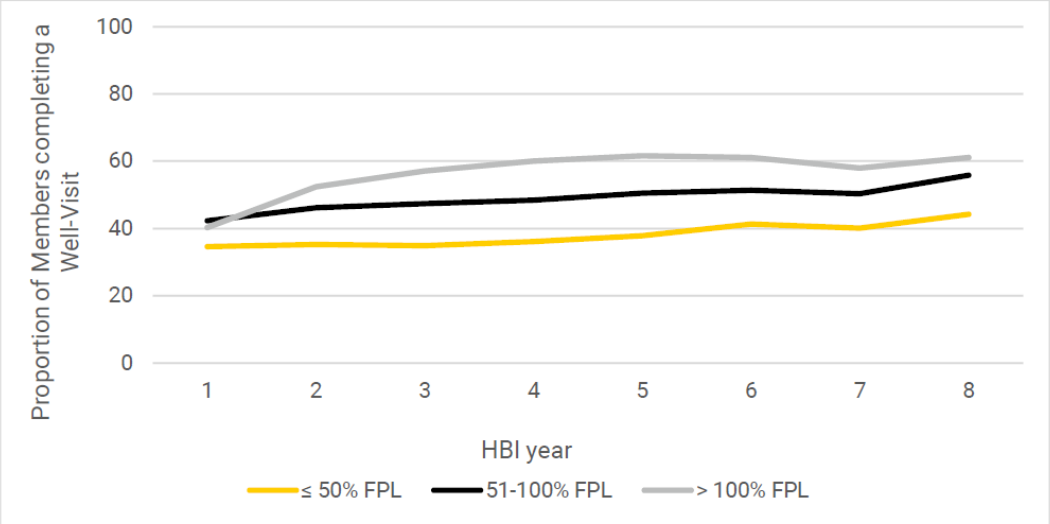


Chi-square p<.05, Don't know coded as not having a wellness exam

There is an increasing trend in the percentage of members completing a well-visit, an HRA, or both required activities by duration of enrollment in a given year. For example, 40% of members with eight years of enrollment have a well-visit compared to 31% for members with only one year of enrollment. There is no regular pattern of change over time in the percentages of members completing both required activities by MCO membership status or by MCO type.

[3] For purposes of the Evaluation, Healthy Behaviors may also be referred to as Healthy Behaviors Incentive (HBI).

Figure 3. Trends in Completion of a Well-Visit by Income Level Between 2014 and 2021



DENTAL WELLNESS PLAN

As previously described, the design of the DWP was modified during the PHE to permanently remove the Healthy Behaviors requirement tied to dental benefits. This resulted in a modified evaluation plan for this component of the Demonstration. Particular emphasis in the new evaluation plan was placed on the knowledge and impact that having a dental wellness exam qualifies as a medical Healthy Behavior and the impact of the dental wellness exam on having an emergency department visit for a non-emergent dental problem.

Several elements of the revised DWP evaluation remain under study. For example, the independent evaluator is currently completing the relevant datasets, provider, and consumer surveys. Preliminary findings indicate the proportion of general dentists who reported accepting new adult patients with DWP remained relatively stable since 2019.

WAIVER OF RETROACTIVE ELIGIBILITY

The COVID-19 PHE impacted the timing of evaluation activities related to the waiver of retroactive eligibility. In particular, the enrollee survey was delayed and will now be completed in July 2024. Therefore, additional time is required to study the impacts of this portion of the Demonstration. However, information provided through the process evaluation indicates that providers have increased their role in initiating Medicaid applications.

COST SHARING

The COVID-19 PHE also impacted the timing and content of the consumer survey related to the copayment for non-emergent use of the ER. Such questions will be included in the 2024 consumer survey. Additionally, relevant datasets are currently being curated and cleaned for analyses and will be available in the forthcoming Summative Evaluation Report.

COST AND SUSTAINABILITY

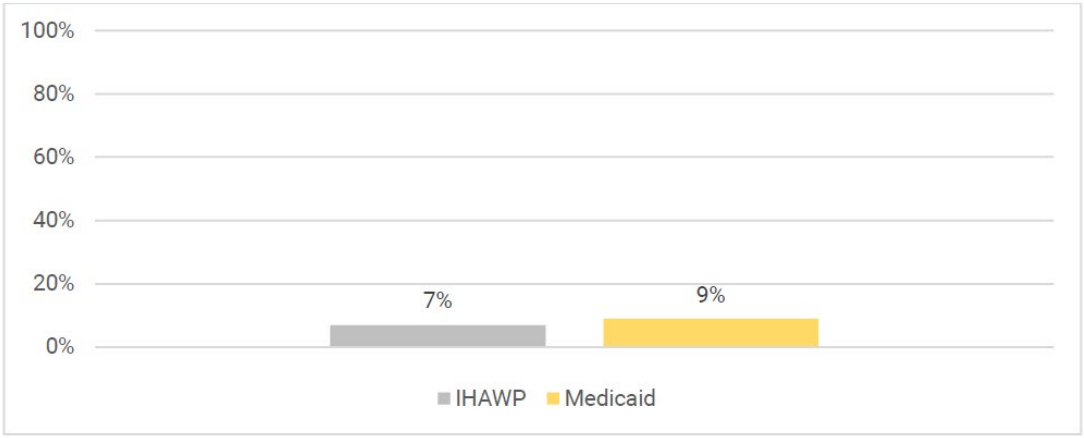
The evaluation of cost and sustainability of the Demonstration was placed on hold during the COVID-19 PHE due to the difficulty in understanding the effects on cost and revenue streams. The independent

evaluator intends to collect applicable cost and revenue streams during 2024 with the intent of understanding whether and how these have changed over time.

WAIVER OF NEMT

A consumer survey conducted in 2022 revealed comparable rates of a reported unmet health care need due to transportation problems among Iowa Medicaid enrollees with full access to the NEMT benefit when compared to IHAWP enrollees for whom NEMT is not a covered benefit. Overall, 7% of IHAWP members reported having any unmet health care need due to transportation problems and 9% of Medicaid members reported an unmet health care need due to transportation (Figure 4). This difference was not statistically significant.

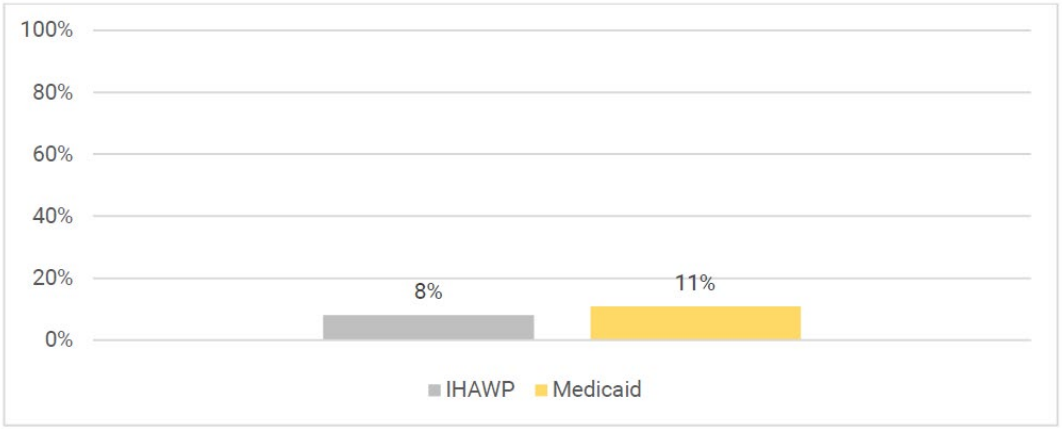
Figure 4. Unmet Health Care Need Due to Transportation Problems in Past Six Months (IHAWP vs. Medicaid)



Chi-square not significant.

Additionally, about one-tenth of members reported having missed an appointment for a regular health care visit in the past six months due to problems with transportation, however, fewer IHAWP members (8%) reported missing an appointment than Medicaid members (11%) and this difference was found to be statistically significant ($p<.05$, Figure 5).

Figure 5. Reported Missed Appointment(s) Due to Transportation Problems in the Past Six Months (IHAWP vs. Medicaid)

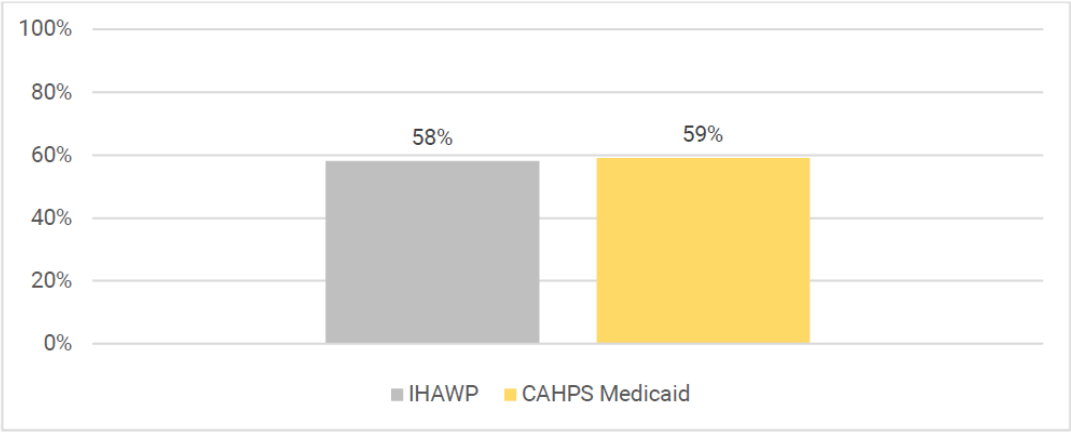


Chi-square p<.05.

MEMBER EXPERIENCES

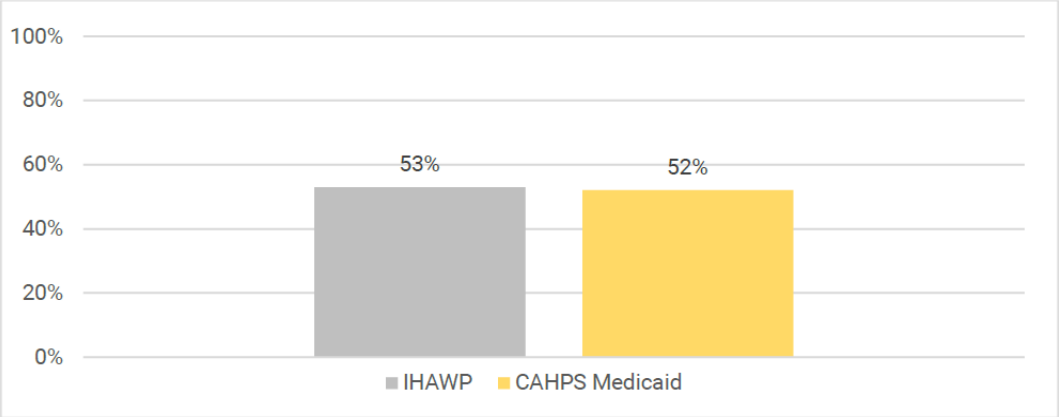
As illustrated in the figures below, IHAWP members in the 2022 Consumer Survey had similar access to timely care and services compared to adults in Medicaid from the 2022 National CAHPS Benchmarking Database.

Figure 6. Always Got Care for Illness, Injury, or Condition as Soon as Needed in Past Six Months



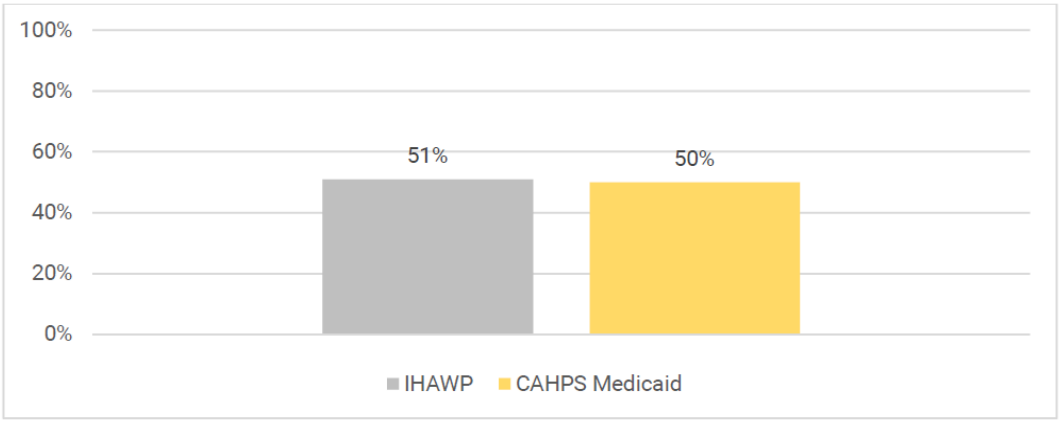
One sample z-test for proportion: not significant

Figure 7. Always Got Check-up or Routine Care Appointment as Soon as Needed in Past Six Months (IHAWP vs. CAHPS Medicaid)



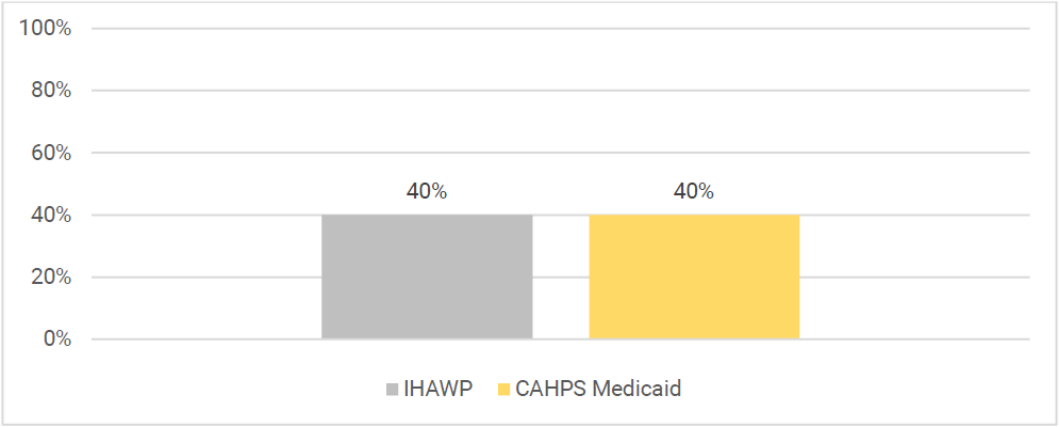
One sample z-test for proportion: not significant

Figure 8. Always Got Appointment with Specialist as Soon as Needed in Past Six Months (IHAWP vs. CAHPS Medicaid)



One sample z-test for proportion: not significant

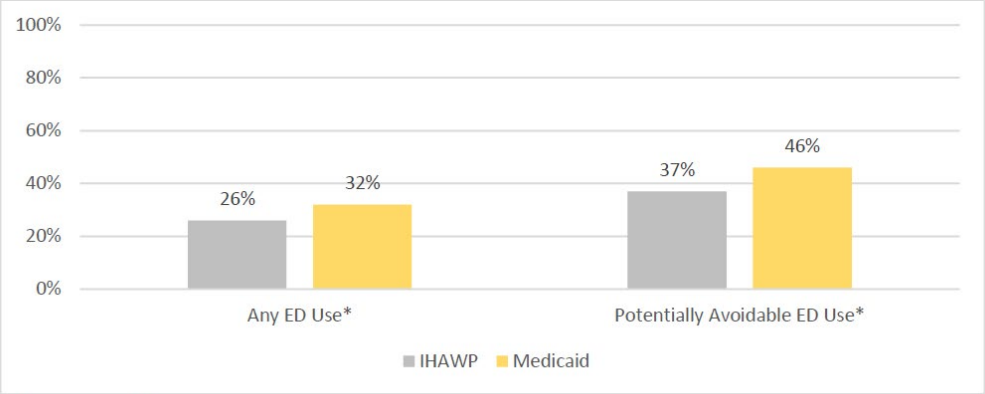
Figure 9. Receipt of Flu Vaccine (IHAWP vs. CAHPS Medicaid)



One sample z-test for proportion: not significant

Additionally, Figure 10 shows the ED experiences of IHAWP and Medicaid members. Around one-quarter (26%) of IHAWP members and around one-third of Medicaid members (32%) used the ED at least once in the six-month period, and that difference was significant. Significantly fewer IHAWP members (37%) compared to Medicaid members (46%) reported that the care at their last visit to the ED could have been provided in a doctor's office.

Figure 10. Emergency Department Use in Past Six Months (IHAWP vs. Medicaid)



** Chi-square p<.05*

EVALUATION DURING THE EXTENSION PERIOD

The State will continue evaluation of the Demonstration during the extension term in accordance with the current CMS-approved evaluation plan. However, the State will discontinue study of the DWP hypotheses given the removal of the dental-related Healthy Behaviors program. Table 2 outlines the hypotheses that will continue to be studied during the extension.

Table 2. Demonstration Evaluation Components

Hypothesis	Research Questions	Analytic Approach
Healthy Behaviors Program		
1. The proportion of members who complete a wellness exam, health risk assessment, or both will vary.	1. What proportion of members complete a wellness exam in a given year? 2. What proportion of members complete an HRA in a given year? 3. What proportion of members complete both required activities in a given year?	Univariate analysis stratified by income group, using t-tests to compare the mean completion rate between income groups.
2. The proportion of members completing a wellness exam, health risk assessment, or both will change over time and by income level.	1. Has the proportion of members completing a wellness exam decreased among lower-income members and increased among higher-income members? 2. Has the proportion of members completing an HRA decreased among lower-income members and increased among higher-income members? 3. Has the proportion of members completing both required activities decreased among lower-income members and increased among higher-income members?	Univariate analysis stratified by income group, using t-tests to compare the mean completion rate between income groups.
3. Member characteristics are associated with the likelihood of completing both required HBI activities.	1. Are older, non-Hispanic white females living in metropolitan counties more likely to complete both required activities? 2. Are members assigned to some MCOs more likely than members assigned to other MCOs to complete both required activities? 3. Is the length of time in the program positively associated with the likelihood of completing both required activities? 4. Are members with more negative social determinants of health (SDoH) less likely to complete both required activities? 5. Is the highest income group most likely to complete both required activities?	Multivariable modified Poisson regression model adjusting for member demographics and health status as well as social determinants of health and community-level factors. In sensitivity analyses, county-level fixed effects will be used.
4. Completing HBI	1. Are members who complete the HBI requirements equally	Bivariate analysis, comparing means

Hypothesis	Research Questions	Analytic Approach
requirements is associated with a member's use of the emergency department (ED).	likely to have an ED visit? 2. Do members who complete the HBI requirements have fewer total ED visits annually? 3. Are members who complete the HBI requirements less likely to have a non-emergent ED visit? 4. Do members who complete the HBI requirements have fewer total nonemergent ED visits annually? 5. Are members who complete the HBI requirements less likely to have a 3-day, 7-day, or 30-day return ED visit? 6. Do members who complete the HBI requirements have fewer total 3day, 7-day, or 30-day return ED visits annually?	of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors. Descriptive statistics, time trends, bivariate analysis, multivariate analysis including propensity score adjusted models and DID models.
5. Completing HBI requirements is associated with a member's use of hospital observation stays.	1. Are members who complete the HBI requirements equally likely to have a hospital observation stay? 2. Do members who complete the HBI requirements have fewer total hospital observation stays annually?	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.
6. Completing HBI requirements is associated with a member's use of inpatient hospital care.	1. Are members who complete the HBI requirements equally likely to be hospitalized? 2. Do members who complete the HBI requirements have fewer total hospitalizations annually? 3. Are members who complete the HBI requirements less likely to have a potentially preventable hospitalization?	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score

Hypothesis	Research Questions	Analytic Approach
	4. Do members who complete the HBI requirements have fewer total potentially preventable hospitalizations annually? 5. Are members who complete the HBI requirements less likely to have a 30-day all-cause readmission? 6. Do members who complete the HBI requirements have fewer total 30- day all-cause readmissions annually?	matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.
7. Completing HBI requirements is associated with shifts in patterns of member's health care utilization.	1. Do members who complete the HBI requirements have fewer potentially preventable hospitalizations as a proportion of total hospitalizations? 2. Do members who complete the HBI requirements have fewer non- emergent ED visits as a proportion of total ED visits? 3. Do members who complete the HBI requirements have more primary care visits as a proportion of total outpatient visits?	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.
8. Completing HBI requirements is associated with a member's health care expenditures.	1. Do members who complete the HBI requirements have lower spending in all categories?	Bivariate analysis, comparing means of members who completed vs. did not complete required activities within each income group using t-tests. Multivariable modified Poisson model among our propensity score matched sample, adjusting for member demographics and health status as well as social determinants of health and community-level factors.
9. Disparities exist in the relationships between HBI completion and outcomes.	1. Do disparities exist in the following populations- high utilizers, individuals with multiple chronic conditions, individuals with OUD, individuals from racial and ethnic	Repeat analyses for above research questions using interaction terms and/or running stratified models

Hypothesis	Research Questions	Analytic Approach
	groups, rural individuals, and by sex?	
10. Members who have been enrolled longer are more aware of the HBI program than those who have been enrolled a shorter period of time.	1. What is the level of awareness about the HBI program among members? 2. How long are members enrolled in the program? 3. Is there a relationship between length of enrollment and awareness of the HBI program?	• Descriptive statistics • T-test • Chi-square
11. Members who have been enrolled longer have more knowledge about the HBI program than those who have been enrolled a shorter period of time.	1. What specific knowledge about the HBI program do members report? 2. Do members understand incentive/disincentive part of the HBI program? 3. Do members know they need to pay a premium monthly? 4. Do members know about the hardship waiver? 5. How long have members been enrolled?	• T-test • Qualitative Analysis
12. Those who are aware of the HBI program are more likely to complete the behaviors (HRA and well exam) compared to those who are not aware.	1. What is the level of awareness of the HBI program? 2. What is the level of completion of the HRA and well exam?	• Chi square • Modified Poisson regression
13. Those who have more knowledge about the HBI program are more likely to complete the behaviors (HRA and well exam) than those with less knowledge.	1. What is the level of knowledge about the HBI program? 2. What is the level of completion of the HRA and well exam?	• Chi square • Modified Poisson regression
14. Member socio-demographic characteristics and perceptions/attitudes are associated with awareness of the HBI program.	1. What is the level awareness of the HBI program? 2. What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members? 3. What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and	• Chi square • Modified Poisson regression • Qualitative analysis

Hypothesis	Research Questions	Analytic Approach
	perceived benefit) of members?	
15. Member socio-demographic characteristics and perceptions/attitudes are associated with knowledge of the HBI program.	1. What is the level knowledge of the HBI program? 2. What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members? 3. What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?	• Descriptive statistics • Modified Poisson regression • Qualitative analysis • Logistic regression
16. Member socio-demographic characteristics and perceptions/attitudes are associated with completion of the HRA and well exam.	1. What is the level of completion of the HRA and well exam? 2. Research Question 16.2: What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members? 3. Research Question 16.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?	• Descriptive statistics • Modified Poisson regression • Qualitative analysis • Logistic regression
17. Members are most likely to hear about the HBI program from their MCO.	1. Where are members learning about the HBI program and HBI program components?	• Descriptive statistics
18. Members report challenges in using hardship waiver.	1. What are the perceptions of the ease of use of the hardship waiver? 2. What are the challenges members report in using the hardship waiver?	• Descriptive statistics • Qualitative analysis
19. Members who do not complete the HRA and wellness exam, report barriers to completing the behaviors.	1. What are the barriers to completing the HRA and wellness exam as reported by the members?	• Descriptive statistics • Qualitative analysis
20. Disenrolled members report no knowledge of the HBI program.	1. What is the level of HBI program knowledge among disenrolled members?	• Descriptive statistics
21. Disenrolled members	1. How do disenrolled members describe the process of	• Descriptive/thematic analysis

Hypothesis	Research Questions	Analytic Approach
describe confusion around the disenrollment process.	learning about their disenrollment?	
22. Disenrolled members report consequences to their disenrollment.	1. What happens after members are disenrolled for non-payment? 2. Will disenrolled members be able to reenroll to health insurance coverage? 3. Do the consequences change over time?	• Descriptive/thematic analysis
Waiver of Retroactive Eligibility		
1. Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.	1. Are people subject to the waiver of retroactive eligibility more likely to enroll in Medicaid relative to members in the same programs prior to the waiver? 2. Do people subject to the waiver of retroactive eligibility have increased enrollment continuity relative to members in the same programs prior to the waiver?	• DID • ITS • CITS • Means test • Descriptive analyses • Survival analysis
2. Eliminating retroactive eligibility will not increase negative financial impacts on members.	1. Are there any negative financial impacts on consumers because of the waiver of retroactive eligibility relative to members in the same programs prior to the waiver?	• DID • ITS
3. Eliminating retroactive eligibility will improve member health.	1. Do people who are subject to waiver of retroactive eligibility have better health outcomes?	• Descriptive analyses
4. Eliminating retroactive eligibility will reduce the annual Medicaid services budget.	1. What are the effects on the Medicaid services budget?	• ITS • Descriptive analyses
5. Providers will increase initiation of Medicaid applications for eligible patients/clients	1. Have health care providers increased the initiation of Medicaid applications for eligible patients/clients?	• Descriptive analyses
Cost Sharing		
1. Members understand the	1. Do members understand the $8 copayment for non-	Descriptive analyses

Hypothesis	Research Questions	Analytic Approach
$8 copayment for non-emergent use of the ER.	emergent use of the ER?	
2. Cost sharing improves member understanding of appropriate ER use.	1. Do members subject to an $8 copayment understand appropriate use of the ER better than members who are not subject to the copay? 2. Do members subject to an $8 copayment understand cost of the ER better than members who are not subject to the copay? 3. Are members subject to an $8 copayment for non-emergent use of the ER less likely to use the ER for non-emergent care? 4. Are members subject to an $8 copayment for non-emergent use of the ER more likely to use the primary care providers for non-emergent care?	• Descriptive analyses • Consumer Surveys • DID • CITS • Comparison of rates
3. Members subject to cost sharing are more likely to establish and utilize a regular source of care as compared to members not subject to cost sharing.	1. Are members who are subject to the $8 copayment for non-emergent ER use more likely to have a regular source of care than those not subject to the copayment? 2. Are members who are subject to the $8 copayment for non-emergent ER use more likely to receive preventive care and chronic care monitoring than those not subject to the copayment?	• Consumer Surveys • DID • Means tests • CITS
4. Cost sharing improves long-term health care outcomes.	1. Do members who are subject to the $8 copayment for non-emergent ER use have more favorable long-term health care outcomes?	• DID • Consumer surveys • Means tests • Descriptive analyses
Cost and Sustainability		
1. Ongoing administrative costs will increase due to implementation of IHAWP.	1. What are the administrative costs associated with IHAWP?	• Descriptive analysis
2. IHAWP will result in short-term outcomes supporting a sustainable	1. What are the changes in revenue streams as a result of IHAWP?	• Descriptive analysis

Hypothesis	Research Questions	Analytic Approach
program.		
3. IHAWP results in intermediate outcomes supporting a sustainable program.	1. How does IHAWP change healthcare expenditures? 2. How does IHAWP change healthcare utilization?	• DID • CITS • Descriptive analysis
4. IHAWP results in long-term outcomes supporting a sustainable program.	1. What are the long-term, state-wide changes resulting from IHAWP?	• CITS
Waiver of NEMT		
1. Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.	1. Are adults in the IHAWP less likely to report barriers to care due to transportation than other adults in Medicaid? 2. Are adults in the IHAWP less likely to report transportation-related barriers to complete HBI requirements than other adults in Medicaid who report awareness of the NEMT benefit? 3. Are adults in the IHAWP less likely to report barriers to care for chronic condition management due to transportation than other adults in Medicaid who report awareness of the NEMT benefit? 4. Are adults in the IHAWP less likely to report unmet need for transportation to health care visits than other adults in Medicaid who report awareness of the NEMT benefit? 5. Are adults in the IHAWP less likely to report worry about the ability to pay for cost of transportation than other adults in Medicaid who report awareness of the NEMT benefit?	• Chi-square test
2. Wellness Plan members without a non-emergency transportation benefit will have equal or lower rates of missed appointments due to access to	1. Are adults in the IHAWP less likely to report transportation-related missed appointments than other adults in Medicaid who receive the NEMT benefit?	• Chi-square test

Hypothesis	Research Questions	Analytic Approach
transportation.		
3. Wellness Plan members without a non-emergency transportation benefit will report a lower awareness of the non-emergency transportation benefit as a part of their health care plan.	1. Do adults in the IHAWP less frequently report that their health care plan provides non-emergency transportation than other adults in Medicaid who receive the NEMT benefit?	• Chi-square test
4. Wellness plan members without a non-emergency transportation benefit will report similar experiences with health care-related transportation regardless of their location or disability status.	1. Do adults in the IHAWP who live in rural areas report similar experiences with health-care related transportation as other adults in Medicaid who receive the NEMT benefit? 2. Do adults in the IHAWP who have limitations to activities of daily living report similar experiences with health-care related transportation as other adults in Medicaid who receive the NEMT benefit?	• Chi-square test
Member Experiences		
1. Wellness Plan members will have equal or greater access to primary care and specialty services.	1. Are adults in the IHAWP more likely to have had an ambulatory or preventive care visit than other adults in Medicaid? 2. Are adults in the IHAWP more likely to report greater access to urgent care than other adults in national estimates from National CAHPS Benchmarking Database? 3. Are adults in the IHAWP more likely to report greater access to routine care than other adults in national estimates from National CAHPS Benchmarking Database? 4. Are adults in the IHAWP more likely to get timely appointments, answers to questions, and have less time in waiting room than other adults in national estimates from National CAHPS Benchmarking Database? 5. Are adults in the IHAWP more likely to know what to do	• Means test • DID • Z-test

Hypothesis	Research Questions	Analytic Approach
	to obtain care after regular office hours than other adults in national estimates from National CAHPS Benchmarking Database? 6. Are adults in the IHAWP more likely to report greater access to specialist care than other adults in national estimates from National CAHPS Benchmarking Database? 7. Are adults in the IHAWP more likely to report greater access to prescription medication than other adults in national estimates from National CAHPS Benchmarking Database?	
2. Wellness Plan members will have equal or greater access to preventive care services.	1. Are women aged 50-64 in the IHAWP more likely to have had a breast cancer screening than other adults in Medicaid? 2. Are women aged 21-64 in the IHAWP more likely to have had a cervical cancer screening than other adults in Medicaid? 3. Are adults in the IHAWP more likely to have had a flu shot in the past year than other adults in national estimates from National CAHPS Benchmarking Database? 4. Are adults with diabetes in the IHAWP more likely to have had Hemoglobin A1c testing than other adults with diabetes in Medicaid? 5. Are adults in the IHAWP more likely to report greater access to preventive care than other adults in national estimates from National CAHPS Benchmarking Database?	• Means test • DID • Z-test • Chi-square test • CITS
3. Wellness Plan members will have equal or greater access to mental and behavioral health services.	1. Research Question 1.3.1: Are adults in IHAWP with major depressive disorder more likely to have higher anti-depressant medication management than other adults with major depressive disorder in Medicaid? 2. Research Question 1.3.2: Are adults in the IHAWP more likely to utilize mental health services than other adults in Medicaid?	• Means test • Survival analyses • DID

Hypothesis	Research Questions	Analytic Approach
4. Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.	1. Are adults in the IHAWP more likely to have fewer non-emergent ED visits than other adults in Medicaid? 2. Are adults in the IHAWP more likely to have fewer follow-up ED visits than other adults in Medicaid? 3. Are adults in the IHAWP more likely to utilize ambulatory care than other adults in Medicaid? 4. What other circumstances are associated with overutilization of ED?	• DID • Means tests
5. Wellness Plan members will experience equal or less churning.	1. Are adults in the IHAWP less likely to have gaps in health insurance coverage over the past 12 months than other adults in Medicaid? 2. Are adults in the IHAWP more likely to have higher rates of consecutive coverage than other adults in Medicaid? 3. Are adults in the IHAWP less likely to change plans or lose eligibility during the year than other adults in Medicaid?	• CITS • DID • Qualitative thematic coding • Means tests
6. Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.	1. Are adults in the IHAWP more likely to have a personal doctor than other adults in national estimates from National CAHPS Benchmarking Database? 2. Are adults in the IHAWP more likely to have an easier time changing personal doctor/PCP than other adults in Medicaid/(than in prior years)? 3.	• Chi-square test • Z-test
7. Wellness Plan members will have equal or better quality of care.	1. Are adults in the IHAWP less likely to receive antibiotic treatment for acute bronchitis than other adults in Medicaid? 2. Are adults aged 40-64 with COPD in IHAWP more likely to have pharmacotherapeutic management of COPD exacerbation than other adults in Medicaid? 3. Are adults in the IHAWP more likely to self-report receipt of flu shot than other adults in Medicaid? 4. Are adults in the IHAWP less likely to report visiting the	• Chi-square test • Means test

Hypothesis	Research Questions	Analytic Approach
	ED for non-emergent care than other adults in Medicaid?	
8. Wellness Plan members will have equal or lower rates of hospital admissions.	1. Are adults in the IHAWP less likely to have hospital admissions for COPD, diabetes short-term complications, CHF or asthma than other adults in Medicaid? 2. Are adults in the IHAWP less likely to utilize general hospital/acute care than other adults in Medicaid? 3. Are adults in the IHAWP less likely to have an acute readmission within 30 days of being discharged for acute inpatient stay than other adults in Medicaid? 4. Are adults in the IHAWP less likely to have a self-reported hospitalization in the previous 6 months than other adults in Medicaid? 5. Are adults in the IHAWP less likely to have a self-reported 30-day hospital readmission in the previous 6 months than other adults in Medicaid?	• Chi-square test • Means test
9. Wellness Plan members will report equal or greater satisfaction with the care provided.	1. Are adults in the IHAWP more likely to report that their personal doctor communicated well with them during office visits than other adults in national estimates from National CAHPS Benchmarking Database? 2. Are adults in the IHAWP more likely to report that their provider supported them in taking care of their own health than other adults in Medicaid? 3. Are adults in the IHAWP more likely to report that their provider paid attention to their mental or emotional health than other adults in Medicaid? 4. Are adults in the IHAWP more likely to report that their provider paid attention to the care they received from other providers than other adults in national estimates from National CAHPS Benchmarking Database? 5. Are adults in the IHAWP more likely to report higher ratings of their personal doctor than other adults in national estimates from National CAHPS Benchmarking	• Z-test • Chi-square test

Hypothesis	Research Questions	Analytic Approach
	Database? 6. Are adults in the IHAWP more likely to report higher ratings of their overall care than other adults in national estimates from National CAHPS Benchmarking Database? 7. Are adults in the IHAWP more likely to report higher ratings of their MCO health plan than other adults in national estimates from National CAHPS Benchmarking Database?	

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Appendix D: Quality Assurance Monitoring

The State has a robust quality oversight plan for continually monitoring the performance of the MCOs and dental PAHPs delivering services to enrollees under the Demonstration. The Iowa Medicaid Managed Care Oversight and Reporting Bureau is primarily responsible for monitoring performance and reviewing compliance.

MCO AND PAHP QUALITY ASSURANCE MONITORING

Ongoing analytics are available on the HHS Agency Dashboard, which is accessible at https://hhs.iowa.gov/dashboard_welcome. Prior to HHS' implementation of the Dashboard, data collection and performance analysis were made available through a series of monthly, quarterly and annual reports. These reports can be accessed at https://hhs.iowa.gov/programs/welcome-iowa-medicaid/resources-and-reports/performance-reports.

QUALITY AND ACCESS TO CARE

MCOs serving IHAWP enrollees must demonstrate compliance with contractually mandated network adequacy standards. As outlined in Table 3 below, enrollees have access to network providers in accordance with contract requirements. Geographic access reports through the first quarter of SFY 2024 are available at https://hhs.iowa.gov/programs/welcome-iowa-medicaid/resources-and-reports/performance-reports. Subsequent reports will be available through the State's Dashboard at https://hhs.iowa.gov/dashboard_welcome.

Table 3. Percentage of Members by MCO with Coverage within Time and Distance Standards (SFY2024; Q1)

Access Standard – 30 minutes/30 miles	Wellpoint (formerly Amerigroup)	Iowa Total Care	Molina
Adult Primary Care	100%	100%	99.5%
Hospital	100%	100%	99.5%
Outpatient Behavioral Health	100%	100%	99.5%

Additionally, the average distance to a dental provider by PAHP is outlined in Table 4 below.

Table 4. Average Distance to Closest Dentist (SFY2024; Q1)

PAHP	Average Distance to 1st Closest Provider	Average Distance to 2nd Closest Provider
Delta Dental of Iowa	4.0 miles 4.4 minutes	5.0 miles 5.6 minutes

PAHP	Average Distance to 1st Closest Provider	Average Distance to 2nd Closest Provider
Managed Care of North America Dental (MCNA)	6.6 miles 7.3 minutes	7.9 miles 8.8 minutes

EXTERNAL QUALITY REVIEW

Additionally, the State contracts with Health Services Advisory Group (HSAG) to conduct an annual external quality review (EQR) in accordance with the requirements at 42 CFR §438.350. The EQR provides an annual assessment of each plan's performance related to quality, timeliness and access to care and services. HSAG performs a series of mandatory and optional EQR activities including compliance monitoring, validation of performance improvement projects and performance measures, network adequacy analysis (inclusive of provider capacity and geographic network distribution), encounter data validation, review and validation of enrollee and provider surveys and calculation of performance measures. A high-level overview of key findings from activities from the FY2022 EQR for the MCOs and PAHPs is provided in Tables 5 and 6 below.

Table 5. MCO Summary EQR Activity Findings[4]

MCO	Amerigroup (now Wellpoint)	Iowa Total Care
Validation of Performance Improvement Projects	Met	Met
Validation of Performance Measures	Reported/Met	Reported/Met
Network Adequacy for Adult Primary Care and Behavioral Health	Contract standards met for all provider types	Contract standards met for majority of provider types
Encounter Data Validation	Met/Generally high level of data accuracy	Met/Generally high level of data accuracy
Consumer Assessment of Healthcare Providers and Systems Analysis (CAHPS)	Scores statistically significantly higher than 2021 national averages for multiple quality, access, and timeliness measures	Scores statistically significantly higher than 2021 national averages for multiple quality and timeliness measures

[4] Molina had not yet begun serving Iowa Medicaid or IHAWP enrollees in FY2022.

Table 6. Dental PAHP Summary EQR Activity Findings

PAHP	Delta Dental	MCNA
Validation of Performance Improvement Projects	Partially Met	Met
Validation of Performance Measures	Reported/Met	Reported/Met
Network Adequacy	Contract standards met for general dentists for all members	Contract standards met for general dentists for all members except fewer than 0.1% of urban members
Encounter Data Validation	Met/Data highly corroborated for most items	Met/Complete and accurate data for most items

Additionally, as noted in the 2022 EQR Technical Report, statewide HEDIS 2021 weighted averages for both MCOs serving the Demonstration population were at or above the 75th percentile for multiple measures, as reflected in Table 7, below. Four star ratings reflect measures at or above the 75th percentile but below the 90th percentile, while five star ratings reflect measures above the 90th percentile.

Table 7. 2021 HEDIS Ratings At or Above 75% Percentile

Measure	Weighted Average	Star Rating
Access to Preventive Care		
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	79.39%	4
Living with Illness		
Comprehensive Diabetes Care		
HbA1c Testing	89.69%	5
Blood Pressure Control (<140/90 mm Hg)	70.37%	4
Controlling High Blood Pressure		
Controlling High Blood Pressure	65.91%	4
Behavioral Health		
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence		
7 Day Follow-Up - Total	49.66%	5

Measure	Weighted Average	Star Rating
30 Day Follow-Up - Total	55.58%	5
Follow-Up After ED Visit for Mental Illness		
7 Day Follow-Up - Total	64.52%	5
30 Day Follow-Up - Total	75.67%	5
Follow-Up After Hospitalization for Mental Illness		
7 Day Follow-Up - Total	52.37%	4
30 Day Follow-Up - Total	71.53%	4
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total	62.35%	5
Engagement of AOD Treatment—Total	22.88%	5
Medication Management		
Use of Opioids at High Dosage*		
Use of Opioids at High Dosage	1.92%	4
Use of Opioids from Multiple Providers*		
Multiple Pharmacies	1.31%	4

*For this indicator, a lower rate indicates better performance.

Appendix E: Public Notice Summary

The State is conducting public notice and tribal notice in accordance with 42 CFR §431.408. A summary of comments received and any applicable waiver updates in response to comments will be completed pending completion of the public and tribal notice periods.

Appendix E1: Abbreviated Public Notice

NOTICE OF IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC COMMENT PERIOD FOR IOWA HEALTH AND WELLNESS PLAN EXTENSION

Notice is hereby given that the Iowa Department of Health and Human Services (HHS) will hold public hearings on the renewal of the §1115 Iowa Health and Wellness Plan Demonstration which is set to expire December 31, 2024. HHS intends to request extension of the Demonstration for an additional five years pursuant to §1115(a) and §1915(h)(2) of the Social Security Act.

Hearings offer an opportunity for the public to provide written or verbal comments about the Demonstration extension. All comments will be summarized and taken into consideration prior to submission to the Centers for Medicare and Medicaid Services (CMS). Hearings will be held at the following dates, times, and locations:

HEARING #1	**HEARING #2**	**HEARING #3**
April 26, 2024 10 a.m. to 11 a.m. CST Urbandale Public Library Meeting Room A/B 3520 86th St Urbandale, IA 50322	May 2, 2024 4 p.m. to 5 p.m. CST Iowa Medicaid Townhall Meeting https://www.zoomgov.com/j/1612132439 Meeting ID: 161 213 2439 Or Call in by Phone 669-254-5252	May 16, 2024 1 p.m. to 4 p.m. Medical Assistance Advisory Council (MAAC) Meeting https://www.zoomgov.com/j/1605445705 Meeting ID: 160 544 5705 Or Call in by Phone 669-254-5252

The Iowa Health and Wellness Plan was created to provide comprehensive health care coverage to low-income, uninsured Iowans ages 19 to 64. The State seeks to continue the current program structure and requests an extension of all current federal waivers.

A full public notice, Demonstration extension documents, and information about the Iowa Health and Wellness Plan are available at https://hhs.iowa.gov/public-notice/2024-04-17/ihawp-extension and non-electronic copies will be made available for review at HHS Field Offices.

Written comments may be addressed to Jeanette Brandner, Department of Health and Human Services, Iowa Medicaid, 1305 East Walnut, Des Moines, IA 50319-0114. Comments may also be sent via electronic mail to: jbrandn@dhs.state.ia.us through May 17, 2024 at 4:30 p.m. Please include “1115 Renewal” in the subject line.

Submitted by:
Elizabeth Matney, Director
Iowa Medicaid
Iowa Department of Health and Human Services

Appendix E2: Public Notice

NOTICE OF IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC COMMENT PERIOD FOR IOWA HEALTH AND WELLNESS PLAN EXTENSION

Notice is hereby given that the Iowa Department of Health and Human Services (HHS) will hold public hearings on the renewal of the §1115 Iowa Health and Wellness Plan Demonstration (Demonstration), which is set to expire December 31, 2024. HHS intends to request extension of the Demonstration for an additional five years pursuant to §1115(a) and §1915(h)(2) of the Social Security Act with no modifications to current program operations.

Hearings offer an opportunity for the public to provide written or verbal comments about the Demonstration extension. All comments will be summarized and taken into consideration prior to submission to the Centers for Medicare and Medicaid Services (CMS). Hearings will be held at the following dates, times, and locations:

HEARING #1	**HEARING #2**	**HEARING #3**
April 26, 2024 10 a.m. to 11 a.m. CST Urbandale Public Library Meeting Room A/B 3520 86th St Urbandale, IA 50322	May 2, 2024 4 p.m. to 5 p.m. CST Iowa Medicaid Townhall Meeting https://www.zoomgov.com/j/1612132439 Meeting ID: 161 213 2439 Or Call in by Phone 669-254-5252	May 16, 2024 1 p.m. to 4 p.m. Medical Assistance Advisory Council (MAAC) Meeting https://www.zoomgov.com/j/1605445705 Meeting ID: 160 544 5705 Or Call in by Phone 669-254-5252

This notice provides details about the Demonstration and serves to open the 30-day public comment period. The comment period closes May 17, 2024 at 4:30 p.m..

GOALS AND OBJECTIVES

The Iowa Health and Wellness Plan (IHAWP) seeks to further the objectives of Medicaid by:

1. Improving enrollee health and wellness through the encouragement of healthy behaviors and use of preventive services.
2. Increasing enrollee engagement and accountability in their health care.
3. Increasing enrollee's access to dental care.

Additionally, the Dental Wellness Plan (DWP) seeks to achieve the following goals related to dental services:

1. Ensure member access to and quality of dental services.
2. Allow for the seamless delivery of services by providers.
3. Improve the oral health of DWP enrollees by encouraging engagement in preventive services and compliance with treatment goals.
4. Encourage linkage to a dental home.

DEMONSTRATION ELIGIBILITY

No changes are proposed to program eligibility. During the extension period, the Demonstration will continue to target individuals who are eligible in the adult group under the State Plan.

Table 3: IHAWP Eligibility

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
The Adult Group	§1902(a)(10)(A)(i)(VIII) 42 CFR §435.119	0 – 133% Federal Poverty Level (FPL)

Iowa Medicaid enrollees who do not meet one of the following exclusions, will continue to be enrolled in the DWP portion of the Demonstration during the extension: (i) enrollment in the Program of All-Inclusive Care for the Elderly (PACE); (ii) enrollment in the Health Insurance Premium Payment Program (HIPP); (iii) presumptively eligible; (iv) nonqualified immigrants receiving time-limited coverage of certain emergency medical conditions; (v) persons eligible only for the Medicare Savings Program; (vi) medically needy; and (vii) enrollees during periods of retroactive eligibility.

ENROLLMENT AND FISCAL PROJECTIONS

Annual enrollment and aggregate annual expenditures are not expected to increase or decrease as a result of the extension of this Demonstration. The State is not seeking any expenditure authorities under this Demonstration and CMS has previously determined that this Demonstration is budget neutral as documented in CMS' June 24, 2021 approval.

BENEFITS

The Demonstration extension will not modify current covered benefits, which are described in the IHAWP alternative benefit plan (ABP). Dental benefits also remain unchanged under this extension, with members no longer required to complete two dental healthy behavior activities annually or pay a monthly dental contribution to receive full dental coverage in accordance with the State's December 2021 Demonstration amendment.

COST SHARING

Current cost sharing will remain unchanged by this extension. All IHAWP members have no cost-sharing during their first year of enrollment. During the second year, enrollees at or above 50% FPL who do not complete required healthy behaviors (i.e., health risk assessment and

annual exam) during their first year of enrollment will be required to pay a monthly premium during the subsequent enrollment year, subject to a 30-day healthy behavior grace period. Individuals below 50% of the FPL, medically frail and members in the Health Insurance Premium Payment (HIPP) population, and all individuals who self-attest to a financial hardship are exempt from the required premium payment.

Monthly premium amounts will not exceed $5 per month for nonexempt households from 50% up to 100% of FPL, and $10 per month for nonexempt households between 100% and 133% of FPL. Enrollees are allowed a 90-day premium grace period, and enrollees under 100% FPL cannot be disenrolled for nonpayment of a premium, nor can an individual be denied an opportunity to re-enroll due to nonpayment of a premium. Individuals over 100% may be disenrolled for nonpayment but they can reapply. After 90 days, unpaid premiums may be considered a collectible debt owed to the State. Finally, the State will impose an $8 copayment for non-emergency use of the emergency room consistent with Iowa's Medicaid State Plan and with all federal requirements.

DELIVERY SYSTEM

Managed care organizations (MCOs) will continue to be responsible for delivering all IHAWP covered benefits, with the exception of dental benefits, which are carved out and delivered to enrollees through a prepaid ambulatory health plan (PAHP).

Enrollment of Demonstration participants in managed care and the program is mandatory, with the exception of certain populations described in the State's §1915(b) Iowa High Quality Healthcare Initiative Waiver, and Alaskan Natives and American Indians are enrolled voluntarily. Excepted populations continue to receive services through the fee-for-service delivery system outlined in Iowa's Medicaid State Plan.

WAIVER AUTHORITY

The State requests continuation of all currently approved federal waivers with no changes.

EXPENDITURE AUTHORITY

There are currently no expenditure authorities required to operate the Demonstration and the State is not requesting any federal expenditure authorities with this extension.

EVALUATION

The State proposes to continue the evaluation of the Demonstration during the extension term in accordance with the current CMS-approved evaluation plan. The only planned modification is discontinuance of the DWP hypotheses from the study due to the removal of the dental-related Healthy Behaviors program in December 2021. Table 2 outlines the hypotheses and research questions that will continue during the extension.

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Table 2: Evaluation Hypotheses and Research Questions During Demonstration Extension

Hypothesis	Research Questions
Healthy Behaviors Program	
9. The proportion of members who complete a wellness exam, health risk assessment (HRA), or both will vary.	4. What proportion of members complete a wellness exam in a given year? 5. What proportion of members complete an HRA in a given year? 6. What proportion of members complete both required activities in a given year?
10. The proportion of members completing a wellness exam, health risk assessment, or both will change over time and by income level.	4. Has the proportion of members completing a wellness exam decreased among lower-income members and increased among higher-income members? 5. Has the proportion of members completing an HRA decreased among lower-income members and increased among higher-income members? 6. Has the proportion of members completing both required activities decreased among lower-income members and increased among higher-income members?
11. Completing Healthy Behavior Incentive (HBI) requirements is associated with a member's use of hospital observation stays.	3. Are members who complete the HBI requirements equally likely to have a hospital observation stay? 4. Do members who complete the HBI requirements have fewer total hospital observation stays annually?
12. Completing HBI requirements is associated with a member's use of inpatient hospital care.	7. Are members who complete the HBI requirements equally likely to be hospitalized? 8. Do members who complete the HBI requirements have fewer total hospitalizations annually? 9. Are members who complete the HBI requirements less likely to have a potentially preventable hospitalization? 10. Do members who complete the HBI requirements have fewer total potentially preventable hospitalizations annually? 11. Are members who complete the HBI requirements less likely to have a 30-day all-cause readmission? 12. Do members who complete the HBI requirements have fewer total 30- day all-cause readmissions annually?

Hypothesis	Research Questions
13. Completing HBI requirements is associated with shifts in patterns of member's health care utilization.	4. Do members who complete the HBI requirements have fewer potentially preventable hospitalizations as a proportion of total hospitalizations? 5. Do members who complete the HBI requirements have fewer non- emergent ED visits as a proportion of total ED visits? 6. Do members who complete the HBI requirements have more primary care visits as a proportion of total outpatient visits?
14. Completing HBI requirements is associated with a member's health care expenditures.	2. Do members who complete the HBI requirements have lower spending in all categories?
18. Disparities exist in the relationships between HBI completion and outcomes.	2. Do disparities exist in the following populations- high utilizers, individuals with multiple chronic conditions, individuals with OUD, individuals from racial and ethnic groups, rural individuals, and by sex?
19. Members who have been enrolled longer are more aware of the HBI program than those who have been enrolled a shorter period of time.	4. What is the level of awareness about the HBI program among members? 5. How long are members enrolled in the program? 6. Is there a relationship between length of enrollment and awareness of the HBI program?
20. Members who have been enrolled longer have more knowledge about the HBI program than those who have been enrolled a shorter period of time.	6. What specific knowledge about the HBI program do members report? 7. Do members understand incentive/disincentive part of the HBI program? 8. Do members know they need to pay a premium monthly? 9. Do members know about the hardship waiver? 10. How long have members been enrolled?
21. Those who are aware of the HBI program are more likely to complete the behaviors (HRA and well exam) compared to those who are not aware.	3. What is the level of awareness of the HBI program? 4. What is the level of completion of the HRA and well exam?
22. Those who have more knowledge about the HBI program are more likely to complete the behaviors (HRA and well exam) than those with less knowledge.	3. What is the level of knowledge about the HBI program? 4. What is the level of completion of the HRA and well exam?
23. Member socio-demographic characteristics and	4. What is the level awareness of the HBI program? 5. What are the socio-demographic characteristics (age, gender, income,

Hypothesis	Research Questions
perceptions/attitudes are associated with awareness of the HBI program.	education, employment, race, and ethnicity) of members? 6. What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?
24. Member socio-demographic characteristics and perceptions/attitudes are associated with knowledge of the HBI program.	4. What is the level knowledge of the HBI program? 5. What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members? 6. What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?
25. Member socio-demographic characteristics and perceptions/attitudes are associated with completion of the HRA and well exam.	4. What is the level of completion of the HRA and well exam? 5. Research Question 16.2: What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members? 6. Research Question 16.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?
26. Members are most likely to hear about the HBI program from their MCO.	2. Where are members learning about the HBI program and HBI program components?
20. Members report challenges in using hardship waiver.	3. What are the perceptions of the ease of use of the hardship waiver? 4. What are the challenges members report in using the hardship waiver?
21. Members who do not complete the HRA and wellness exam, report barriers to completing the behaviors.	2. What are the barriers to completing the HRA and wellness exam as reported by the members?
21. Disenrolled members report no knowledge of the HBI program.	2. What is the level of HBI program knowledge among disenrolled members?
23. Disenrolled members describe confusion around the disenrollment process.	2. How do disenrolled members describe the process of learning about their disenrollment?
24. Disenrolled members report consequences to their disenrollment.	4. What happens after members are disenrolled for non-payment? 5. Will disenrolled members be able to reenroll to health insurance coverage? 6. Do the consequences change over time?

Hypothesis	Research Questions
Waiver of Retroactive Eligibility	
2. Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.	3. Are people subject to the waiver of retroactive eligibility more likely to enroll in Medicaid relative to members in the same programs prior to the waiver? 4. Do people subject to the waiver of retroactive eligibility have increased enrollment continuity relative to members in the same programs prior to the waiver?
3. Eliminating retroactive eligibility will not increase negative financial impacts on members.	2. Are there any negative financial impacts on consumers because of the waiver of retroactive eligibility relative to members in the same programs prior to the waiver?
6. Eliminating retroactive eligibility will improve member health.	2. Do people who are subject to waiver of retroactive eligibility have better health outcomes?
7. Eliminating retroactive eligibility will reduce the annual Medicaid services budget.	2. What are the effects on the Medicaid services budget?
8. Providers will increase initiation of Medicaid applications for eligible patients/clients	2. Have health care providers increased the initiation of Medicaid applications for eligible patients/clients?
Cost Sharing	
2. Members understand the $8 copayment for non-emergent use of the ER.	5. Do members understand the $8 copayment for non-emergent use of the ER?
6. Cost sharing improves member understanding of appropriate ER use.	5. Do members subject to an $8 copayment understand appropriate use of the ER better than members who are not subject to the copay? 6. Do members subject to an $8 copayment understand cost of the ER better than members who are not subject to the copay? 7. Are members subject to an $8 copayment for non-emergent use of the ER less likely to use the ER for non-emergent care? 8. Are members subject to an $8 copayment for non-emergent use of the ER more likely to use the primary care providers for non-emergent care?
7. Members subject to cost sharing are more likely to establish and utilize a regular source of care as compared to	3. Are members who are subject to the $8 copayment for non-emergent ER use more likely to have a regular source of care than those not subject to the copayment?

Hypothesis	Research Questions
members not subject to cost sharing.	4. Are members who are subject to the $8 copayment for non-emergent ER use more likely to receive preventive care and chronic care monitoring than those not subject to the copayment?
8. Cost sharing improves long-term health care outcomes.	2. Do members who are subject to the $8 copayment for non-emergent ER use have more favorable long-term health care outcomes?
Cost and Sustainability	
2. Ongoing administrative costs will increase due to implementation of IHAWP.	5. What are the administrative costs associated with IHAWP?
6. IHAWP will result in short-term outcomes supporting a sustainable program.	2. What are the changes in revenue streams as a result of IHAWP?
7. IHAWP results in intermediate outcomes supporting a sustainable program.	3. How does IHAWP change healthcare expenditures? 4. How does IHAWP change healthcare utilization?
8. IHAWP results in long-term outcomes supporting a sustainable program.	2. What are the long-term, state-wide changes resulting from IHAWP?
Waiver of NEMT	
2. Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.	6. Are adults in the IHAWP less likely to report barriers to care due to transportation than other adults in Medicaid? 7. Are adults in the IHAWP less likely to report transportation-related barriers to complete HBI requirements than other adults in Medicaid who report awareness of the NEMT benefit? 8. Are adults in the IHAWP less likely to report barriers to care for chronic condition management due to transportation than other adults in Medicaid who report awareness of the NEMT benefit? 9. Are adults in the IHAWP less likely to report unmet need for transportation to health care visits than other adults in Medicaid who report awareness of the NEMT benefit? 10. Are adults in the IHAWP less likely to report worry about the ability to pay for cost of transportation than other adults in Medicaid who report awareness of the NEMT benefit?

Hypothesis	Research Questions
5. Wellness Plan members without a non-emergency transportation benefit will have equal or lower rates of missed appointments due to access to transportation.	2. Are adults in the IHAWP less likely to report transportation-related missed appointments than other adults in Medicaid who receive the NEMT benefit?
6. Wellness Plan members without a non-emergency transportation benefit will report a lower awareness of the non-emergency transportation benefit as a part of their health care plan.	2. Do adults in the IHAWP less frequently report that their health care plan provides non-emergency transportation than other adults in Medicaid who receive the NEMT benefit?
7. Wellness plan members without a non-emergency transportation benefit will report similar experiences with health care-related transportation regardless of their location or disability status.	3. Do adults in the IHAWP who live in rural areas report similar experiences with health-care related transportation as other adults in Medicaid who receive the NEMT benefit? 4. Do adults in the IHAWP who have limitations to activities of daily living report similar experiences with health-care related transportation as other adults in Medicaid who receive the NEMT benefit?
Member Experiences	
2. Wellness Plan members will have equal or greater access to primary care and specialty services.	8. Are adults in the IHAWP more likely to have had an ambulatory or preventive care visit than other adults in Medicaid? 9. Are adults in the IHAWP more likely to report greater access to urgent care than other adults in national estimates from National CAHPS Benchmarking Database? 10. Are adults in the IHAWP more likely to report greater access to routine care than other adults in national estimates from National CAHPS Benchmarking Database? 11. Are adults in the IHAWP more likely to get timely appointments, answers to questions, and have less time in waiting room than other adults in national estimates from National CAHPS Benchmarking Database? 12. Are adults in the IHAWP more likely to know what to do to obtain care after regular office hours than other adults in national estimates from National CAHPS Benchmarking Database? 13. Are adults in the IHAWP more likely to report greater access to specialist

Hypothesis	Research Questions
	care than other adults in national estimates from National CAHPS Benchmarking Database? 14. Are adults in the IHAWP more likely to report greater access to prescription medication than other adults in national estimates from National CAHPS Benchmarking Database?
3. Wellness Plan members will have equal or greater access to preventive care services.	6. Are women aged 50-64 in the IHAWP more likely to have had a breast cancer screening than other adults in Medicaid? 7. Are women aged 21-64 in the IHAWP more likely to have had a cervical cancer screening than other adults in Medicaid? 8. Are adults in the IHAWP more likely to have had a flu shot in the past year than other adults in national estimates from National CAHPS Benchmarking Database? 9. Are adults with diabetes in the IHAWP more likely to have had Hemoglobin A1c testing than other adults with diabetes in Medicaid? 10. Are adults in the IHAWP more likely to report greater access to preventive care than other adults in national estimates from National CAHPS Benchmarking Database?
10. Wellness Plan members will have equal or greater access to mental and behavioral health services.	3. Research Question 1.3.1: Are adults in IHAWP with major depressive disorder more likely to have higher anti-depressant medication management than other adults with major depressive disorder in Medicaid? 4. Research Question 1.3.2: Are adults in the IHAWP more likely to utilize mental health services than other adults in Medicaid?
11. Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.	5. Are adults in the IHAWP more likely to have fewer non-emergent ED visits than other adults in Medicaid? 6. Are adults in the IHAWP more likely to have fewer follow-up ED visits than other adults in Medicaid? 7. Are adults in the IHAWP more likely to utilize ambulatory care than other adults in Medicaid? 8. What other circumstances are associated with overutilization of ED?
12. Wellness Plan members will experience equal or less churning.	4. Are adults in the IHAWP less likely to have gaps in health insurance coverage over the past 12 months than other adults in Medicaid? 5. Are adults in the IHAWP more likely to have higher rates of consecutive

Hypothesis	Research Questions
	coverage than other adults in Medicaid? 6. Are adults in the IHAWP less likely to change plans or lose eligibility during the year than other adults in Medicaid?
13. Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.	4. Are adults in the IHAWP more likely to have a personal doctor than other adults in national estimates from National CAHPS Benchmarking Database? 5. Are adults in the IHAWP more likely to have an easier time changing personal doctor/PCP than other adults in Medicaid/(than in prior years)? 6.
14. Wellness Plan members will have equal or better quality of care.	5. Are adults in the IHAWP less likely to receive antibiotic treatment for acute bronchitis than other adults in Medicaid? 6. Are adults aged 40-64 with COPD in IHAWP more likely to have pharmacotherapeutic management of COPD exacerbation than other adults in Medicaid? 7. Are adults in the IHAWP more likely to self-report receipt of flu shot than other adults in Medicaid? 8. Are adults in the IHAWP less likely to report visiting the ED for non-emergent care than other adults in Medicaid?
15. Wellness Plan members will have equal or lower rates of hospital admissions.	6. Are adults in the IHAWP less likely to have hospital admissions for COPD, diabetes short-term complications, CHF or asthma than other adults in Medicaid? 7. Are adults in the IHAWP less likely to utilize general hospital/acute care than other adults in Medicaid? 8. Are adults in the IHAWP less likely to have an acute readmission within 30 days of being discharged for acute inpatient stay than other adults in Medicaid? 9. Are adults in the IHAWP less likely to have a self-reported hospitalization in the previous 6 months than other adults in Medicaid? 10. Are adults in the IHAWP less likely to have a self-reported 30-day hospital readmission in the previous 6 months than other adults in Medicaid?
16. Wellness Plan members will report equal or greater satisfaction with the care provided.	8. Are adults in the IHAWP more likely to report that their personal doctor communicated well with them during office visits than other adults in national estimates from National CAHPS Benchmarking Database?

Hypothesis	Research Questions
	9. Are adults in the IHAWP more likely to report that their provider supported them in taking care of their own health than other adults in Medicaid? 10. Are adults in the IHAWP more likely to report that their provider paid attention to their mental or emotional health than other adults in Medicaid? 11. Are adults in the IHAWP more likely to report that their provider paid attention to the care they received from other providers than other adults in national estimates from National CAHPS Benchmarking Database? 12. Are adults in the IHAWP more likely to report higher ratings of their personal doctor than other adults in national estimates from National CAHPS Benchmarking Database? 13. Are adults in the IHAWP more likely to report higher ratings of their overall care than other adults in national estimates from National CAHPS Benchmarking Database? 14. Are adults in the IHAWP more likely to report higher ratings of their MCO health plan than other adults in national estimates from National CAHPS Benchmarking Database?

SUBMISSION OF COMMENTS

This notice and all Demonstration extension documents are available online at: https://hhs.iowa.gov/public-notice/2024-04-17/ihawp-extension. To reach all stakeholders, non-electronic copies will also be made available for review at HHS Field Offices. A full list of HHS Field Office locations is available at https://hhs.iowa.gov/about/hhs-office-locations.

Written comments may be addressed to Jeanette Brandner, Department of Health and Human Services, Iowa Medicaid, 1305 East Walnut, Des Moines, IA 50319-0114. Comments may also be sent via electronic mail to the attention of HHS, Iowa Health and Wellness Plan at: jbrandn@dhs.state.ia.us through May 17, 2024 at 4:30 p.m. After the comment period has ended, a summary of comments received will be made available at: https://hhs.iowa.gov/public-notice/2024-04-17/ihawp-extension.

Submitted by:

Elizabeth Matney

Medicaid Director

Iowa Department of Health and Human Services

Appendix E3: Tribal Notice

NOTICE OF IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TRIBAL COMMENT PERIOD FOR IOWA HEALTH AND WELLNESS PLAN EXTENSION

Notice is hereby given to all federally recognized tribes, Indian Health Programs and Urban Indian Organizations within the State of Iowa that the Iowa Department of Health and Human Services (HHS) will be submitting a request to the Centers for Medicare and Medicaid Services (CMS) to extend the §1115 Iowa Health and Wellness Plan Demonstration (Demonstration), which is set to expire December 31, 2024. HHS is proposing to extend the Demonstration for an additional five years pursuant to §1115(a) and §1915(h)(2) of the Social Security Act.

PROPOSAL

The Iowa Health and Wellness Plan is a Medicaid program that was created to provide comprehensive health care coverage to low-income, uninsured Iowans ages 19 to 64. HHS is seeking to extend the Demonstration for another five years with no substantive changes.

TRIBAL IMPACT

American Indian and Alaskan Native (AI/AN) populations located in the State of Iowa will continue to receive services through the Iowa Health and Wellness Plan and will be able to voluntarily enroll in the managed care delivery system. Dental benefits will continue to be delivered to Demonstration enrollees through a prepaid ambulatory health plan (PAHP). Additionally, AI/AN enrollees will continue to have coverage with no cost sharing or premium obligation. To address AI/AN members and providers who voluntarily elect to participate in managed care, HHS contracts with participating MCOs and PAHPs include protections for Indian health care providers participating in Medicaid as required pursuant to Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (AARA).

SUBMISSION OF COMMENTS

A copy of the Demonstration extension request and relevant attachments are included with this notice. Written comments may be addressed to Christy Casey, Department of Health and Human Services, Iowa Medicaid, 1305 East Walnut, Des Moines, IA 50319-0114. Comments may also be sent via electronic mail to ccasey@dhs.state.ia.us. Please include the phrase “1115 Renewal” in the subject line. HHS would be happy to schedule a phone or in-person consultation to discuss the amendments in further detail. All comments must be received by May 17, 2024, at 4:30pm CST.

Submitted by:

Elizabeth Matney
Medicaid Director
Iowa Department of Health and Human Services