

NOTICE OF IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES

**PUBLIC COMMENT PERIOD FOR IOWA HEALTH
AND WELLNESS PLAN EXTENSION**

Posted: May 16, 2024

Notice is hereby given that the Iowa Department of Health and Human Services (HHS) is extending its public comment period 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. The initial 30-day public comment period was set to close May 17, 2024 at 4:30 p.m. The comment period will now close on June 17, 2024 at 4:30 p.m.

In addition to extending the public comment period, the following updates have been made to this public notice:

- Added Table 2 to provide an overview of anticipated annual enrollment and expenditures over the five year renewal period.
- Added the waiver authorities the State will be requesting during the renewal period.
- Provided further description of covered benefits.
- Updated Table 3 to include the dental-related hypotheses and research questions currently contained in the CMS-approved evaluation plan.
- Provided the link to the CMS website where all Demonstration materials are also available.

In addition to the two public hearings already held on the Demonstration extension, a third public hearing will be held as follows:

DATE: May 16, 2024

TIME: 1 p.m. to 4 p.m. CST

LOCATION: Medical Assistance Advisory Council (MAAC) Meeting
https://www.zoomgov.com/j/1_605445705

Meeting ID: 160 544 5705

Or call in by Phone 669-254-5252

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 1: 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. Table 2 provides an overview of anticipated annual enrollment and expenditures over the five year renewal period.

Table 2: Demonstration Enrollment and Expenditures

	DEMONSTRATION YEARS					TOTAL
	2025	2026	2027	2028	2029	
Adult Group Enrollees	192,545	194,470	196,415	198,379	200,363	982,171
DWP Enrollees	659,701	666,298	672,961	679,691	686,488	3,365,138
Demonstration Expenditures	\$ 2,089,073,341	\$ 2,143,082,820	\$ 2,197,547,213	\$ 2,260,603,249	\$ 2,308,788,235	\$ 10,999,094,858

BENEFITS

The Demonstration extension will not modify current covered benefits, which are fully described in the IHAWP alternative benefit plan (ABP). IHAWP benefits are comprehensive and include doctor visits, prescription drugs, preventive health services, mental health services, inpatient care, emergency care, and more. 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 (HIPPP) 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 the currently approved federal waivers, as described below. This includes technical changes to remove waiver authorities associated with the former DWP Healthy Behaviors program, which was discontinued in December 2021.

1. Premiums **Section 1902(a)(14) insofar as it incorporates Section 1916**

To the extent necessary to enable the state to charge premiums beyond applicable Medicaid limits to the Iowa Wellness Plan demonstration populations above 50 percent of the federal poverty level. Combined premiums and cost-sharing is subject to a quarterly aggregate cap of 5 percent of family income.

2. Methods of Administration **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to relieve the state of the responsibility to assure transportation to and from providers for individuals in the demonstration for the new adult group beneficiaries. Medically frail beneficiaries and those eligible for EPSDT services are exempt from this waiver of NEMT.

3. Comparability **Section 1902(a)(17)**

To the extent necessary to permit the state to provide reduced cost sharing for the newly eligible population through an \$8 copay for non-emergency use of the emergency department. This copay will not apply to other Medicaid populations; copays applied to other Medicaid populations will not be imposed on this population.

4. Proper and Efficient Administration **Section 1902(a)(17)**

To the extent necessary to permit the state to contract with a single dental benefit plan administrator to provide dental services to beneficiaries affected by the Iowa Wellness Plan section 1115 demonstration.

5. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to permit the state to require enrollees to receive dental services through a carved-out contracted dental benefit with no access to other providers.

6. Amount, Duration, and Scope of Services **Section 1902(a)(10)(B)**

To the extent necessary to enable the state to provide benefit packages to demonstration populations that differ from the state plan benefit package.

7. Retroactive Eligibility **Section 1902(a)(10) and (a)(34)**

To the extent necessary to enable the state not to provide three months of retroactive eligibility for state plan populations. The waiver of retroactive eligibility does not apply to pregnant women (and during the 60-day period beginning on the last day of the pregnancy), infants under age 1, and children under 19 years of age.

The waiver of retroactive eligibility also does not apply to applicants who are eligible for nursing facility services based on level of care, who had been a resident of a nursing facility in any of the three months prior to an application, and who are otherwise eligible for Medicaid. For persons who are exempted from the waiver due to eligibility for nursing facility services, retroactive eligibility would be provided for any particular months in which the applicant was a nursing facility resident.

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. Table 3 outlines the hypotheses and research questions that will continue during the extension.

Table 3: Evaluation Hypotheses and Research Questions During Demonstration Extension

Hypothesis	Research Questions
Healthy Behaviors Program	
1. The proportion of members who complete a wellness exam, health risk assessment (HRA), or both will vary.	<ul style="list-style-type: none"> • What proportion of members complete a wellness exam in a given year? • What proportion of members complete an HRA in a given year? • What proportion of members complete both required activities in a given year?
2. The proportion of members completing a wellness exam, health risk assessment, or both will change over time and by income level.	<ul style="list-style-type: none"> • Has the proportion of members completing a wellness exam decreased among lower-income members and increased among higher-income members? • Has the proportion of members completing an HRA decreased among lower-income members and increased among higher-income members? • Has the proportion of members completing both required activities decreased among lower-income members and increased among higher-income members?
3. Member characteristics are associated with the likelihood of completing both required HBI activities.	<ul style="list-style-type: none"> • Are older, non-Hispanic white females living in metropolitan counties more likely to complete both required activities? • Are members assigned to some MCOs more likely than members assigned to other MCOs to complete both required activities? • Is the length of time in the program positively associated with the likelihood of completing both required activities?
4. Completing HBI requirements is associated with a	<ul style="list-style-type: none"> • Are members who complete the HBI requirements equally likely to have an ED visit? • Do members who complete the HBI requirements have fewer

Hypothesis	Research Questions
<p>member's use of the emergency department (ED).</p>	<p>total ED visits annually?</p> <ul style="list-style-type: none"> • Are members who complete the HBI requirements less likely to have a non-emergent ED visit? • Do members who complete the HBI requirements have fewer total nonemergent ED visits annually? • Are members who complete the HBI requirements less likely to have a 3-day, 7-day, or 30-day return ED visit? • Do members who complete the HBI requirements have fewer total 3day, 7-day, or 30-day return ED visits annually?
<p>5. Completing Healthy Behavior Incentive (HBI) requirements is associated with a member's use of hospital observation stays.</p>	<ul style="list-style-type: none"> • Are members who complete the HBI requirements equally likely to have a hospital observation stay? • Do members who complete the HBI requirements have fewer total hospital observation stays annually?
<p>6. Completing HBI requirements is associated with a member's use of inpatient hospital care.</p>	<ul style="list-style-type: none"> • Are members who complete the HBI requirements equally likely to be hospitalized? • Do members who complete the HBI requirements have fewer total hospitalizations annually? • Are members who complete the HBI requirements less likely to have a potentially preventable hospitalization? • Do members who complete the HBI requirements have fewer total potentially preventable hospitalizations annually? • Are members who complete the HBI requirements less likely to have a 30-day all-cause readmission? • Do members who complete the HBI requirements have fewer total 30- day all-cause readmissions annually?
<p>7. Completing HBI requirements is associated with shifts in patterns of</p>	<ul style="list-style-type: none"> • Do members who complete the HBI requirements have fewer potentially preventable hospitalizations as a proportion of total hospitalizations?

Hypothesis	Research Questions
member's health care utilization.	<ul style="list-style-type: none"> • Do members who complete the HBI requirements have fewer non- emergent ED visits as a proportion of total ED visits? • Do members who complete the HBI requirements have more primary care visits as a proportion of total outpatient visits?
8. Completing HBI requirements is associated with a member's health care expenditures.	<ul style="list-style-type: none"> • Do members who complete the HBI requirements have lower spending in all categories?
9. Disparities exist in the relationships between HBI completion and outcomes.	<ul style="list-style-type: none"> • 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?
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.	<ul style="list-style-type: none"> • What is the level of awareness about the HBI program among members? • How long are members enrolled in the program? • Is there a relationship between length of enrollment and awareness of the HBI program?
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.	<ul style="list-style-type: none"> • What specific knowledge about the HBI program do members report? • Do members understand incentive/disincentive part of the HBI program? • Do members know they need to pay a premium monthly? • Do members know about the hardship waiver? • How long have members been enrolled?
12. Those who are	<ul style="list-style-type: none"> • What is the level of awareness of the HBI program?

Hypothesis	Research Questions
<p>aware of the HBI program are more likely to complete the behaviors (HRA and well exam) compared to those who are not aware.</p>	<ul style="list-style-type: none"> • What is the level of completion of the HRA and well exam?
<p>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.</p>	<ul style="list-style-type: none"> • What is the level of knowledge about the HBI program? • What is the level of completion of the HRA and well exam?
<p>14. Member socio-demographic characteristics and perceptions/attitudes are associated with awareness of the HBI program.</p>	<ul style="list-style-type: none"> • What is the level awareness of the HBI program? • What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members? • What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?
<p>15. Member socio-demographic characteristics and perceptions/attitudes are associated with knowledge of the HBI program.</p>	<ul style="list-style-type: none"> • What is the level knowledge of the HBI program? • What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members? • What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?
<p>16. Member socio-demographic</p>	<ul style="list-style-type: none"> • What is the level of completion of the HRA and well exam? • Research Question 16.2: What are the socio-demographic

Hypothesis	Research Questions
<p>characteristics and perceptions/attitudes are associated with completion of the HRA and well exam.</p>	<p>characteristics (age, gender, income, education, employment, race, and ethnicity) of members?</p> <ul style="list-style-type: none"> • Research Question 16.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?
<p>17. Members are most likely to hear about the HBI program from their MCO.</p>	<ul style="list-style-type: none"> • Where are members learning about the HBI program and HBI program components?
<p>18. Members report challenges in using hardship waiver.</p>	<ul style="list-style-type: none"> • What are the perceptions of the ease of use of the hardship waiver? • What are the challenges members report in using the hardship waiver?
<p>19. Members who do not complete the HRA and wellness exam, report barriers to completing the behaviors.</p>	<ul style="list-style-type: none"> • What are the barriers to completing the HRA and wellness exam as reported by the members?
<p>20. Disenrolled members report no knowledge of the HBI program.</p>	<ul style="list-style-type: none"> • What is the level of HBI program knowledge among disenrolled members?
<p>21. Disenrolled members describe confusion around the disenrollment process.</p>	<ul style="list-style-type: none"> • How do disenrolled members describe the process of learning about their disenrollment?
<p>22. Disenrolled members report consequences to</p>	<ul style="list-style-type: none"> • What happens after members are disenrolled for non-payment? • Will disenrolled members be able to reenroll to health

Hypothesis	Research Questions
their disenrollment.	insurance coverage? <ul style="list-style-type: none"> Do the consequences change over time?
23. Higher levels of awareness and perceived ability to comply with requirements will be associated with receiving a dental wellness exam.	<ul style="list-style-type: none"> What level of awareness do members have of a dental wellness exam qualifying as a HB? What are the barriers to receiving a dental wellness exam in order to meet the HB requirements? What member characteristics are associated with awareness that dental wellness exams qualify for HB requirements? How are members learning that receiving a dental wellness exam qualifies for HB requirements? Do members view receiving a dental wellness exam as a favorable alternative to monthly premiums?
24. IHAWP members will have equal or greater access to a dental wellness exam and other dental services because dental wellness exams qualify as a healthy behavior.	<ul style="list-style-type: none"> What proportion of IHAWP members receive a dental wellness exam annually? Are adults in the IHAWP more likely to have had a dental wellness exam than other adults in Medicaid? Are IHAWP members able to find a dental home where they can receive a dental wellness exam? Are adults in the IHAWP less likely to visit the ED for non-traumatic dental conditions (NTDCs) than other adults in Medicaid?
25. The oral health status of IHAWP members who receive a dental wellness exam will improve over time.	<ul style="list-style-type: none"> How do members who have received a dental wellness exam in the past year rate their oral health as compared to those that did not?
Waiver of Retroactive Eligibility	
1. Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.	<ul style="list-style-type: none"> 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?

Hypothesis	Research Questions
	<ul style="list-style-type: none"> Do people subject to the waiver of retroactive eligibility have increased enrollment continuity relative to members in the same programs prior to the waiver?
2. Eliminating retroactive eligibility will not increase negative financial impacts on members.	<ul style="list-style-type: none"> 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?
3. Eliminating retroactive eligibility will improve member health.	<ul style="list-style-type: none"> Do people who are subject to waiver of retroactive eligibility have better health outcomes?
4. Eliminating retroactive eligibility will reduce the annual Medicaid services budget.	<ul style="list-style-type: none"> What are the effects on the Medicaid services budget?
5. Providers will increase initiation of Medicaid applications for eligible patients/clients	<ul style="list-style-type: none"> Have health care providers increased the initiation of Medicaid applications for eligible patients/clients?
Cost Sharing	
1. Members understand the \$8 copayment for non-emergent use of the ER.	<ul style="list-style-type: none"> Do members understand the \$8 copayment for non-emergent use of the ER?
2. Cost sharing improves member understanding of appropriate ER use.	<ul style="list-style-type: none"> Do members subject to an \$8 copayment understand appropriate use of the ER better than members who are not subject to the copay? Do members subject to an \$8 copayment understand cost of the ER better than members who are not subject to the copay? Are members subject to an \$8 copayment for non-emergent use of the ER less likely to use the ER for non-emergent care? 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?
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.	<ul style="list-style-type: none"> 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? 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

Hypothesis	Research Questions
<p>4. Cost sharing improves long-term health care outcomes.</p>	<p>copayment?</p> <ul style="list-style-type: none"> Do members who are subject to the \$8 copayment for non-emergent ER use have more favorable long-term health care outcomes?
<p>Cost and Sustainability</p>	
<p>1. Ongoing administrative costs will increase due to implementation of IHAWP.</p>	<ul style="list-style-type: none"> What are the administrative costs associated with IHAWP?
<p>2. IHAWP will result in short-term outcomes supporting a sustainable program.</p>	<ul style="list-style-type: none"> What are the changes in revenue streams as a result of IHAWP?
<p>3. IHAWP results in intermediate outcomes supporting a sustainable program.</p>	<ul style="list-style-type: none"> How does IHAWP change healthcare expenditures? How does IHAWP change healthcare utilization?
<p>4. IHAWP results in long-term outcomes supporting a sustainable program.</p>	<ul style="list-style-type: none"> What are the long-term, state-wide changes resulting from IHAWP?
<p>Waiver of NEMT</p>	
<p>1. Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.</p>	<ul style="list-style-type: none"> Are adults in the IHAWP less likely to report barriers to care due to transportation than other adults in Medicaid? 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? 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? 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? 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? Are IHAWP members less likely to have transportation-related barriers to dental care than other adult Medicaid members who are eligible for NEMT benefits?

Hypothesis	Research Questions
<p>2. Wellness Plan members without a non-emergency transportation benefit will have equal or lower rates of missed appointments due to access to transportation.</p>	<ul style="list-style-type: none"> • Are adults in the IHAWP less likely to report transportation-related missed appointments than other adults in Medicaid who receive the NEMT benefit?
<p>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.</p>	<ul style="list-style-type: none"> • 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?
<p>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.</p>	<ul style="list-style-type: none"> • 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? • 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	
<p>1. Wellness Plan members will have equal or greater access to primary care and specialty services.</p>	<ul style="list-style-type: none"> • Are adults in the IHAWP more likely to have had an ambulatory or preventive care visit than other adults in Medicaid? • 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? • 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? • 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? • 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?

Hypothesis	Research Questions
	<p>Database?</p> <ul style="list-style-type: none"> • 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? • 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?
<p>2. Wellness Plan members will have equal or greater access to preventive care services.</p>	<ul style="list-style-type: none"> • Are women aged 50-64 in the IHAWP more likely to have had a breast cancer screening than other adults in Medicaid? • Are women aged 21-64 in the IHAWP more likely to have had a cervical cancer screening than other adults in Medicaid? • 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? • Are adults with diabetes in the IHAWP more likely to have had Hemoglobin A1c testing than other adults with diabetes in Medicaid? • 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?
<p>3. Wellness Plan members will have equal or greater access to mental and behavioral health services.</p>	<ul style="list-style-type: none"> • 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? • Research Question 1.3.2: Are adults in the IHAWP more likely to utilize mental health services than other adults in Medicaid?
<p>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.</p>	<ul style="list-style-type: none"> • Are adults in the IHAWP more likely to have fewer non-emergent ED visits than other adults in Medicaid? • Are adults in the IHAWP more likely to have fewer follow-up ED visits than other adults in Medicaid? • Are adults in the IHAWP more likely to utilize ambulatory care

Hypothesis	Research Questions
	<p>than other adults in Medicaid?</p> <ul style="list-style-type: none"> • What other circumstances are associated with overutilization of ED?
<p>5. Wellness Plan members will experience equal or less churning.</p>	<ul style="list-style-type: none"> • Are adults in the IHAWP less likely to have gaps in health insurance coverage over the past 12 months than other adults in Medicaid? • Are adults in the IHAWP more likely to have higher rates of consecutive coverage than other adults in Medicaid? • Are adults in the IHAWP less likely to change plans or lose eligibility during the year than other adults in Medicaid?
<p>6. Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.</p>	<ul style="list-style-type: none"> • Are adults in the IHAWP more likely to have a personal doctor than other adults in national estimates from National CAHPS Benchmarking Database? • 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)? •
<p>7. Wellness Plan members will have equal or better quality of care.</p>	<ul style="list-style-type: none"> • Are adults in the IHAWP less likely to receive antibiotic treatment for acute bronchitis than other adults in Medicaid? • Are adults aged 40-64 with COPD in IHAWP more likely to have pharmacotherapeutic management of COPD exacerbation than other adults in Medicaid? • Are adults in the IHAWP more likely to self-report receipt of flu shot than other adults in Medicaid? • Are adults in the IHAWP less likely to report visiting the ED for non-emergent care than other adults in Medicaid?
<p>8. Wellness Plan members will have equal or lower rates of hospital admissions.</p>	<ul style="list-style-type: none"> • 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? • Are adults in the IHAWP less likely to utilize general hospital/acute care than other adults in Medicaid?

Hypothesis	Research Questions
	<ul style="list-style-type: none"> • 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? • Are adults in the IHAWP less likely to have a self-reported hospitalization in the previous 6 months than other adults in Medicaid? • 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?
<p>9. Wellness Plan members will report equal or greater satisfaction with the care provided.</p>	<ul style="list-style-type: none"> • 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? • 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? • 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? • 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? • 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? • 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? • 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/2024-05-16/ihawp-extension-2>. 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>.

Additionally, all historical documents associated with the Demonstration are available on the CMS website at <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81706>. Upon the State's submission of the Demonstration extension application to CMS, this page will also be updated to permit submission of comments during the federal comment period.

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 June 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/2024-05-16/ihawp-extension-2>

Submitted by:

Elizabeth Matney

Iowa Medicaid Director

Iowa Department of Health and Human Services