Section 1115 Demonstration Amendment

Iowa Wellness Plan
Project #11-W-00289/5

State of Iowa
Department of Human Services

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Section I – Introduction

In 2013, the Iowa Legislature passed the bi-partisan Iowa Health and Wellness Plan to provide access to healthcare for uninsured, low-income Iowans, while implementing a benefit design intended to address liabilities associated with simply expanding the number of members in traditional Medicaid coverage. The Plan's design seeks to improve outcomes, increase personal responsibility, and ultimately lower costs, while supporting a population that may be new to full healthcare coverage. Key goals were to ensure the Plan 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 private insurance and Medicare markets.

Iowa Health and Wellness Plan members have access to local providers and all Essential Health Benefits, pursuant to the Affordable Care Act. Covered benefits are based on the State employee commercial health insurance plan versus traditional State Plan Medicaid benefits. While these will change under the proposed amendment, current Plan options include:

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

Iowa Medicaid currently administers the Iowa Wellness Plan through several delivery systems including independent primary care physicians (PCPs), accountable care organizations (ACOs), and managed care plans. Services provided by independent PCPs and ACOs are provided on a fee-for-service basis, while managed care plans are compensated based on capitation. The Marketplace Choice Plan allows members to select from participating commercial health care coverage plans available through the Health Insurance Marketplace. Medicaid pays Marketplace Choice member premiums and cost sharing to the commercial health plan on behalf of the member, and members have 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, one has withdrawn from the marketplace, and the other has informed the State it will not be accepting any new members, thereby eliminating coverage options for the current Marketplace Choice Demonstration population.

On January 1, 2014, the Centers for Medicaid and Medicare Services approved the Iowa Wellness Plan §1115 Demonstration Waiver (Project #11-W-00289/5) and the Marketplace Choice §1115 Demonstration Waiver (Project # 11-W-00288/5), thereby enabling the state to implement the Iowa Health and Wellness Plan. Since this time, the healthcare marketplace has seen significant changes. The State has sought §1915(b) waiver authority to implement the High Quality Healthcare Initiative ("Initiative") to ensure high quality, efficient, and coordinated care to Iowa's Medicaid population. Under the Initiative, the State will contract for delivery of health care services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (*hawk-i*) programs.

The proposed amendment seeks to:

1. Modify eligibility under the Iowa Wellness Plan Demonstration to include those persons eligible for the Marketplace Choice Demonstration; and
2. Establish a managed care delivery system for Iowa Wellness Plan Demonstration under concurrent §1915(b) authority.

There are no proposed changes to enrollment, benefits, enrollee rights, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, or other comparable program elements. In addition, the Iowa Marketplace Choice Demonstration will not be amended or terminated as a result of this proposed amendment to the Iowa Wellness Plan Demonstration. The requested effective date of this amendment is January 1, 2016, and is conditioned upon approval of the State's §1915(b) waiver to implement the Initiative, beginning January 1, 2016.

Section II – Public Process

Pursuant to the Iowa Wellness Plan Demonstration (11-W-00289/5) special terms and conditions (STCs), the following provides an explanation of the public process used by the State to reach a decision regarding the requested amendment.

Per STC 15, regarding public notice, tribal consultation, and consultation with interested parties, the State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in Section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration are proposed. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)). In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

A. Public Notice

On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, and a series of public meetings to discuss the Initiative. Stakeholders and members of the public were invited to attend meetings held in Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City, and Sioux City. In total, close to 1,000 people attended and provided DHS with valuable comments and questions. This public engagement strategy was intended to solicit stakeholder feedback on key program design elements and managed care organization (MCO) contract requirements. Subsequent amended versions of the RFP were released on March 26, 2015, and April 22, 2015 which incorporated feedback received through this stakeholder engagement strategy.

With respect to the proposed amendment, the Iowa Medicaid Enterprise (IME) published a notice of the public comment period for changes to various Medicaid waivers related to the Initiative, including the Iowa Wellness Plan Demonstration, on July 17, 2015. The notice was published in a statewide newspaper, and included details of the amendment, as well as the physical and email addresses where interested parties could submit written comments. The period will run from July 17, 2015 to August 21, 2015. Further, the IME sent emails to stakeholder groups to inform them of the amendment and the public comment period. The public notice, waiver documents, and information about the Initiative are were made available at online at: http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization. To reach all

stakeholders, non-electronic copies of all of the aforementioned items were also made available for review at DHS Field Offices.

B. Tribal Consultation

The IME also consulted with Iowa's federally recognized Indian tribes, Indian health programs, and urban Indian health organizations prior to submission of this amendment. Consultation was conducted in accordance with the process outlined in the State's approved Medicaid State Plan, and consisted of an electronic notice directed to Indian Health Service/Tribal/Urban Indian Health (I/T/U) Tribal Leaders and Tribal Medical Directors identified by the Iowa Indian Health Services Liaison. Per the Iowa Medicaid State Plan, this notice was provided at least thirty-five prior to submission (July 14, 2015**)** to CMS and included a copy of the proposed amendment, along with a description of how and where to submit comments or questions.

Section III – Data Analysis

A. Comparative Analysis

Pursuant to the Iowa Wellness Plan Demonstration (11-W-00289/5) special terms and conditions (STCs), the following provides a data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. The analysis includes total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment.

Pursuant to this amendment, effective January 1, 2016, the Marketplace Choice New Adult Group will be eligible for the Iowa Wellness Plan Demonstration. Further, current enrollees will be moved from the Iowa Marketplace Choice Demonstration to the Iowa Wellness Plan Demonstration. As the dental rate is equivalent for both the Wellness Plan New Adult Group, and the Marketplace Choice New Adult Group, there is no change to the overall budget neutrality per member, per month (PMPM) limit.

MEG	Trend	DY 1 (CY 2014) Dental PMPM	DY 2 (CY 2015) Dental PMPM	DY 3 (CY 2016) Dental PMPM
Wellness Plan New Adult Group	4.7%	$24.71	$25.87	$27.09
Marketplace Choice New Adult Group	4.7%			$27.09
Overall				$27.09

B. CHIP Allotment

Pursuant to the Iowa Wellness Plan Demonstration (11-W-00289/5) special terms and conditions (STCs), the following provides an up-to-date CHIP allotment neutrality worksheet.

Not applicable as the CHIP population is not covered under the Iowa Wellness Plan.

Section IV – Description of Amendment

Pursuant to the Iowa Wellness Plan Demonstration (11-W-00289/5) special terms and conditions (STCs), the following provides a detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design.

The Iowa Wellness Plan Demonstration currently offers comprehensive health care coverage to those who are eligible in the new adult group and who receive the alternative benefit plan (ABP) that is the Iowa Wellness plan. The State seeks to amend the Iowa Wellness Plan Demonstration to:

1. Modify eligibility under the Iowa Wellness Plan Demonstration to include those persons eligible for the Marketplace Choice Demonstration (11-W-00288/5); and
2. Establish a managed care delivery system for Iowa Wellness Plan Demonstration under concurrent §1915(b) authority.

A. Modified Eligibility

The Iowa Marketplace Choice Demonstration covers monthly premium and out-of-pocket costs for adults ages 19 to 64, with household incomes from 101% through 133% of FPL. Historically, members could elect to receive coverage through one of two qualified health plans (QHPs)—CoOportunity Health and Coventry Health Care of Iowa. As noted in correspondence from former Director Cindy Mann dated December 30, 2014, CMS is aware of CoOportunity Health's withdrawal from the marketplace in December 2014. More recently, the State was informed that Coventry would not be accepting any new members and does not intend to continue providing coverage to existing members after the State establishes a mandatory managed care delivery system.

To ensure coverage for the Marketplace Choice Demonstration population, the State requests an amendment to the Iowa Wellness Plan Demonstration STCs that would enable the State to no longer require beneficiaries with household incomes above 100% of FPL to enroll in a QHP as a condition of eligibility. As such, adults ages 19 to 64, with household incomes from 101% through 133% of FPL would be eligible to enroll in the Iowa Wellness Plan Demonstration. Iowa Wellness Plan Demonstration program design elements will remain in place for all enrollees including, but not limited to, premium amount limitations and exemptions, and the Healthy Behaviors Incentive Program. Existing Iowa Wellness Plan members will not be affected by this amendment modifying eligibility.

To ensure a smooth and seamless transition for the Marketplace Choice Demonstration population, outreach and enrollment will follow the process identified in Section IV, Subsection B, below. Member notification for this specific population will include an explanation of the waiver amendment and the rationale for the transition. Upon approval of this amendment, the Marketplace Choice Demonstration population will begin receiving benefits through a managed care delivery system and no Iowa Medicaid beneficiaries will be enrolled in a QHP or receiving the Marketplace Choice ABP benefits. However, the State will continue to retain the waiver

authority to provide premium and out-of-pocket coverage for this population should market conditions change and a new QHP enter the market. Marketplace Choice Demonstration reporting will continue as required under the STCs and the State may elect to renew, amend, or terminate this waiver in the future.

B. Delivery System

The Iowa Wellness Plan Demonstration currently provides healthcare coverage through a variety of primary care physician (PCP) coordination, Accountable Care Organizations (ACOs), and managed care models. Models vary by geographic region and are dependent on ACO and/or managed care delivery system readiness; however, most Demonstration participants have access to a PCP that provides referrals and care coordination, and focuses on quality outcomes. PCPs not associated with an ACO are paid on a fee-for-service basis and may receive a per-member per-month (PMPM) payment to coordinate care and provide referrals. PCPs associated with ACOs are paid on a fee-for-service basis and, although they may receive a PMPM payment to coordinate care, other quality incentives are aggregated to the ACO. PCPs are also eligible for quality-based incentive payments. MCOs are paid on a capitated basis and are held to quality standards.

The State has recently submitted a §1915(b) waiver to establish a statewide managed care delivery system for the majority of Iowa Medicaid and waiver beneficiaries, including Demonstration participants. By requiring mandatory enrollment in managed care, the State will be positioned to improve care coordination among providers and incentivize active management of members' healthcare as a whole.

Under the new delivery system, MCOs will be responsible for delivering all Demonstration covered benefits, with the exception of dental benefits, which will continue to be delivered to Demonstration enrollees through a prepaid ambulatory health plan (PAHP). MCOs will be responsible for delivering physical health, behavioral health, and long-term services and supports in a highly coordinated manner. The system is intended to integrate care and improve quality outcomes and efficiencies, while at the same time reducing unnecessary and duplicative services. Enrollment of Demonstration participants will be mandatory, with the exception of certain populations described in the §1915(b) waiver, and Alaskan Natives and American Indians who will be enrolled voluntarily. Excepted populations will continue to receive services through the fee-for-service delivery system outlined in Iowa's Medicaid State Plan.

i. Readiness Review

Prior to implementing the new delivery system, the State will assess plan readiness in accordance with the requirements of 42 CFR §438. Readiness reviews will include, but not be limited to, documentation and confirmation of adequate network capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The State will notify CMS of its intent to conduct a readiness review in advance.

ii. Enrollment

Statewide MCO enrollment in the Initiative will be effective January 1, 2016. The State will begin notifying patients and providers in fall 2015, at which time the Enrollment Broker will begin taking MCO selections and providing choice counseling to assist enrollees. To facilitate the MCO selection process, enrollees will receive enrollment notices that include a tentative MCO assignment based on an algorithm designed to: (1) deal the population evenly among the MCOs; and (2) assign all members of a particular family to the same MCO. As all MCOs are required to extend contract offers to all current Iowa Medicaid enrolled providers, existing provider-beneficiary relationships should be available as the program is implemented. The notice will also include information regarding all available MCO options and will provide the opportunity for enrollees to make an alternative selection prior to the tentative assignment becoming effective. Enrollees will be fully enrolled based on their tentative assignment in the absence of an alternative choice made by the required response date listed in the notice. Once fully enrolled, members will have the opportunity to change MCOs in the first 90 days of enrollment without cause.

iii. Network Adequacy

MCOs are also contractually required to maintain a network sufficient to offer members a choice of providers to the extent possible and appropriate. If a member enrolls with the MCO and is already established with a provider who is not a part of the network, the MCO must make every effort to arrange for the member to continue with the same provider if the member so desires. In addition, for the first six months of an MCO's contract with the State, the MCO must extend contract offers to all currently enrolled Iowa Medicaid providers in good standing, at minimum, at Medicaid fee-for-service rates. The State will provide continuous oversight and monitoring of network adequacy through performance indicators that focus on specific time and distance measures and the provider number, mix, and geographic distribution, including general access standards. MCOs must provide the State written notice at least ninety calendar days in advance of their inability to maintain a sufficient network in any county.

iv. Continuity of Care

The State will ensure continuity of care for transitioning participants by requiring that MCOs honor existing authorizations for covered benefits for a minimum of ninety calendar days, without regard to whether such services are being provided by contract or non-contract providers. MCOs will be required to identify existing prior authorization decisions for new members. Additionally, when a member transitions to another program MCO, the originating MCO shall be responsible for providing the receiving MCO with information on any current service authorizations, utilization data and other applicable clinical information. Participants and providers will be notified in advance of the transition through letters and general public announcements. Information provided will include relevant changes in service delivery, MCO assignment and contact information, procedures for electing a different MCO, and member rights.

v. Quality Oversight

MCOs will also be required to develop critical incident reporting and management in accordance with State requirements, as well as convene a Stakeholder Advisory Board to engage consumers, their representatives, and providers. The State will ensure compliance with all managed care regulations set forth in 42 CFR §438, unless otherwise waived, and that capitation rates are developed and certified as actuarially sound, pursuant to 42 CFR §438.6. Finally, the State will implement a comprehensive quality management and oversight strategy including, but not limited to, monitoring and reporting on finances, member and provider helpline performance, claims payment, prior authorization, care plan development, hearings and appeals, health risk screenings, network composition, and geo-access ratios.

Section V – Evaluation Design

Pursuant to the Iowa Wellness Plan Demonstration (11-W-00289/5) special terms and conditions (STCs), the following provides a description of how the evaluation design will be modified to incorporate the amendment provisions.

The State does not intend to modify the formal waiver evaluation design, as the global questions and hypothesis apply to all Demonstration participants irrespective of delivery system.[1] However, the State recognizes this amendment may affect study population and comparison groups.

For example, the current Wellness Plan study population includes Wellness Plan members previously enrolled in Iowa Care, and those persons who have never been in a public insurance program but have household incomes at or below 100% FPL. In addition, the current evaluation design provides three enrollment options for Demonstration participants that are based on the delivery system in place prior to this amendment:

1. Participants living in counties with access to Meridian Health Plan, the only Medicaid HMO option in the State;
2. Participants statewide with access to the Iowa Medicaid Enterprise PCP option; or
3. Participants in counties with no access to the PCP or HMO options (i.e., fee-for-service members).

Following implementation of the proposed amendment, the study population will also include those persons who have never been in a public insurance program but have household incomes of 101 through 133% FPL. Further, the majority of participants will be enrolled in the Demonstration through an MCO pursuant to concurrent §1915(b) waiver authority.

Regarding Wellness Plan comparison groups, the Medicaid State Plan Income Eligible Group currently includes participants living in counties with access to Meridian Health Plan or Wellness PCP participants. While this data will be available for the Demonstration period prior to implementation of the proposed amendment, it will not be included in the Demonstration assessment following implementation, and the majority of participants will be required to enroll in an MCO (excepted populations will continue to receive services through a fee-for-service delivery system). As a result of these comparison group adjustments, estimated enrollment numbers according to payment structure will be revised to account for both pre- and post-amendment payment structures.

The State will work closely with the evaluation vendor to assess the extent to which the delivery system changes and increased enrollment might impact the evaluation design, and determine whether and how the evaluation design should be modified.

[1] The Wellness Plan Demonstration consists of three component evaluations: (1) Wellness Plan Evaluation; (2) Healthy Behaviors Evaluation; and (3) Dental Evaluation.