Section 1115 Demonstration: Iowa Wellness Plan

Public Comments

Title	Description	Created At
Iowa	I join with other Iowans to ask you to please reject Iowa's request to charge premiums to people with income below the poverty level. Experience has shown that it has a devastating effect on the ability to participate in having insurance and the peace of mind and productivity as a citizen that being insured brings. Thank you.	2013-09-26 15:07
Georgetown University Center for Children and Families and the Center on Budget and Policy Priorities Submit Comments to HHS	See our comments here: http://ccf.georgetown.edu/medicaid/waivers/	2013-09-26 14:05
23 National Groups Share Comments with HHS	see our comments here: http://ccf.georgetown.edu/medicaid/waivers/	2013-09-26 14:04
Comments from National Health Law Program	The National Health Law Program submits the below comments to Iowa's Iowa Wellness Plan and Marketplace Choice Plan. Full comments will be available on our website at www.healthlaw.org > Issues > Health Reform > NHeLP Comments. September 26, 2013 VIA ELECTRONIC SUBMISSION Centers for Medicare & Medicaid Services Department of Health and Human Services P.O. Box 8016 Baltimore, MD 21244-8016 Re: Iowa Wellness Plan §1115 Demonstration Application Dear Sir/Madam: The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments to both of Iowa's proposed § 1115 Demonstration Applications, the Iowa Wellness Plan (IWP) and the Marketplace Choices Plan (MCP). NHeLP recommends that HHS not approve the IWP and the MCP applications for § 1115 authority exactly as requested. The applications include provisions that clearly or arguably are not authorized by any law. We urge HHS to address these problems and require Iowa to bring the proposals to a legally approvable form. We urge HHS to work with Iowa to achieve a Medicaid Expansion that will serve future Medicaid enrollees well, including those inside Iowa benefiting from these proposals and those in other states who may pursue similar proposals. We request that HHS zealously enforce its stated policies and the legal limits of Medicaid § 1115 demonstration law, to ensure progress in Iowa without opening the door to policies that ignore the fundamental nature of Medicaid as an entitlement program.	2013-09-26 13:45

Title	Description	Created At
	Second, we ask that before HHS takes action on this request, it take steps to address its own "stewardship of federal Medicaid resources." GAO, Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency at 32 (June 2013). As the GAO recently concluded, "HHS's [budget neutrality] policy is not reflected in its actual practices and, contrary to sound management practices, is not adequately documented….[T]he policy and processes lack transparency regarding criteria." Id. A. Legal Authority for Premium Assistance In its MCP application, Iowa proposes to conduct a § 1115 demonstration program to use individual market premium assistance to implement a Medicaid Expansion. It is our understanding that Iowa proposes to conduct individual market premium assistance relying on authority at § 1905(a). However, the statute and legislative history create serious questions about the validity of this claimed authority. Section 1905(a) defines "medical assistance" and, for the most part, is a listing of services that can or must be included in this definition. By contrast, Congress has dealt with premium assistance in other, specific provisions of the Act. Congress has authorized states to conduct group or employer coverage premium assistance, which are unambiguously and carefully detailed in statute at §§ 1906 and 1906A. Notwithstanding two very recent policies from HHS (in regulatory and sub-regulatory guidance), there is no history of statutory or regulatory guidance for § 1905(a) authority. Given the uncertainty of the statutory authority and the untested regulatory framework, we believe it is incumbent upon HHS to be extremely cautious and exacting in the approval of any such authority, and even more so for related waivers. HHS should hold tightly to the principles announced in its March 2013 Question and Answer document. And under these circumstances, HHS must also be unmistakably clear as to the waiver authorities being granted and their legal limits. B. Single State Agency In addition to premium assistance authority concerns, Iowa's request, as currently written, fails to ensure that the single state Medicaid agency will remain in charge of the Medicaid program for affected populations, as the Medicaid Act requires. The application does not provide the general public or HHS with information and specifics establishing that the single state agency will continue to make administrative and policy decisions for the program. By law, the single state agency must be in control and accountable for developing and implementing Medicaid coverage. While Iowa may not formally delegate away Medicaid authority, it in effect surrenders control over the majority of benefits for an entire category of enrollees. As currently proposed, Iowa will not control many benefits package details, authorization criteria, and provider contracts and terms but will leave these to health plans. The application only envisions a "written agreement" between the state and the issuers "outlining expectations" of the state. Such an agreement does little to reduce the concern that the health plan would act as an independent entity with its own authority contrary to what Medicaid law permits. NHeLP is very supportive of HHS requiring written agreements between the involved entities to satisfy the legal requirement for a single state agency, clearly delineating roles and responsibilities, with the ultimate authority and	

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	responsibility housed in the Medicaid agency. However, the application is sparse on details and the mere presence of a written agreement "outlining expectations" does not satisfy this requirement. HHS should require more of Iowa as a condition of approval. While assuring consumer protections and enabling ongoing reporting and monitoring, this would also address some of the GAO's conclusions that find HHS processes lack the supporting evidence required to justify deviations from historical requirements. GAO, supra. at 32. C. Limits of § 1115 Waiver Authority Prior to addressing specific features of the requested waivers, we believe it is important to address one repeated misapplication of § 1115 authority within these waiver applications. § 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902. Anything outside of § 1902 is not legally waivable through the 1115 demonstration process. Despite this legal fact, Iowa repeatedly requests waiver of requirements that lie outside of § 1902. These waiver requests, sometimes explicit and other times necessitated by their objectives, include attempts to skirt requirements in § 1906, § 1916, § 1916A, § 1927, and § 1937. None of these waiver requests are permissible because the substantive requirement rests outside of 1902 and independently requires state compliance. In other words, any reference to the provision in section 1902, which could be waived, does not and cannot also waive the independent, freestanding requirements of these Medicaid Act provisions. Such waivers are also patently contrary to all of HHS' stated regulation and policy on premium assistance. In particular, Iowa also seeks to waive several requirements contained within § 1937. However, as Iowa designs a Medicaid Expansion implementing § 1937 benefits, it cannot waive § 1937 requirements which lie outside of § 1902. Iowa attempts to avoid this problem by identifying citations in § 1902(a) to waive – but none of these change the fact there is an independent requirement at § 1937. Consequently, Iowa cannot properly waive EPSDT (protected at § 1937(a)(1)(A)(ii)), FQHC or RHC services (protected at § 1937(b)(4)), any EHB services including maternity care and pediatric dental and visions services (protected at § 1937(b)(5)), or family planning services and supplies (protected at § 1937(b)(7)). Moreover, placed outside of 1902 by Congress these provisions have been repeatedly amended to be strengthened, thus evidencing their core roles as objectives of the Medicaid Act. Finally, Iowa cannot, in this proposal, circumvent these requirements in § 1937 by requesting waiver of § 1902(k)(1). Iowa's MCP proposal (along with IWP) is predicated on receiving enhanced matching funds (100% FMAP in 2014) for its Medicaid Expansion population. However, under § 1903(i)(26), Iowa cannot receive any matching funds for the Medicaid Expansion population that are not tied to coverage of § 1937 benefits. To put it simply, HHS cannot waive elements of § 1937 and pay enhanced FFP.	
Iowa Primary Care Association's comments on Iowa Wellness Plan	Overall, the Iowa Primary Care Association and our 14 Federally Qualified Health Centers (FQHCs) are pleased with the compromise reached by the Iowa Legislature and Governor Branstad that is reflected in the Iowa	2013-09-26 08:43

Title	Description	Created At
	Wellness Plan. However, we have three areas of concern, which are outlined below. Waiving Non-emergency Transportation and EPSDT: We disagree with IME's request to waive non-emergency transportation and EPSDT services for individuals between the ages of 19 and 21. We do not feel IME's reasoning behind this request – i.e. "to standardize the benefit package for participants on the Iowa Wellness Plan, the Iowa Marketplace Choice Plan, and individuals receiving subsidized coverage through the Marketplace" – is valid. Even though low-income Iowans will have access to services closer to home through this program, many will still encounter transportation barriers that prevent them from getting to their health care provider for appointments, even when their provider is located in the same town. Without transportation assistance, many enrollees will find it difficult or impossible to successfully complete the required healthy behaviors services. Similarly, continuing to provide EPSDT services for those 19-21 years old is essential to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. Medically Frail: We appreciate IME's recognition of the needs of the medically frail through this waiver application, and we support the default enrollment of the medically frail between 0%-133% FPL into State Plan coverage. We recommend that IME's definition of "medically frail" be broadened to be more inclusive of individuals who have more complex needs for medical care and management. Among our recommendations for this definition are: those whose native language is not English; individuals in the Medicaid lock-in program; persons who have experienced traumatic experiences (such as victims of domestic violence, ****** assault, or trafficking); individuals experiencing homelessness; HIV positive individuals; and those diagnosed with any rare medical condition that, without appropriate intervention could lead to serious morbidity or mortality (such as thalassemia major, cancer, etc.). Retroactive Eligibility: The section 1115 applications propose ending the current Medicaid provision of retroactive eligibility. Under current Medicaid provisions, individuals are eligible for coverage at the time of their application and Medicaid can even be billed for some services the individual received prior to enrollment. While the development of the Iowa Health Insurance Marketplace and the expansion of the Medicaid program should reduce the number of individuals who become enrolled at the time of a specific medical event, there will still be instances where individuals may need to become enrolled at the time of a specific medical event. Ending retroactive eligibility would mean that, in these instances, the hospitals, emergency rooms, or individuals would bear these immediate costs. We encourage the State to include retroactive eligibility.	
Iowa Citizens for Community Improvement's comments on Iowa Wellness Plan	September 25, 2013 Dear Secretary Sebelius: Iowa Citizens for Community Improvement (Iowa CCI) is a 38 year old grassroots community organization. We have over 3,500 dues paying	2013-09-25 13:30

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	members in all 99 counties in Iowa. We work on four "people first" issues areas – factory farms and the environment, immigrant rights, clean elections and a fair economy for all, which includes social security, Medicare, Medicaid and predatory lending. We are writing on behalf of our membership and low-income families throughout Iowa to express our strong opposition to Iowa's two proposals for Section 1115 Medicaid Waivers—Iowa Marketplace Choice Plan and Iowa Wellness Plan, which were submitted to CMS on August 23, 2013. We fully support Iowa's decision to accept federal Medicaid funding to extend coverage to low-income parents and adults. However, we strongly oppose the provisions in the proposal that would impose monthly premiums on people with incomes above 50 percent of the poverty line. We urge you to withhold approval of the requested waiver unless all provisions that would authorize the imposition of premiums on individuals or families whose income is below the poverty level. By definition, anyone living on income between 50 percent and 100 percent of the poverty level, currently only $11,775 to $23,550 per year for a family of four, is already unable to make ends meet and provide decently for all family members. In designing the Medicaid program, Congress recognized that these families cannot afford to pay for health care coverage. Research has shown that participation in the Medicaid program has provided not only access to care but has helped poor families achieve more financial security than they would have in the absence of Medicaid coverage. Recognizing the critical impedance of Medicaid for low-income families and their inability to make ends meet even without paying premiums for Medicaid coverage, HHS has never approved a waiver that would allow a state to charge premiums on people below the poverty level. This is no time to change this longstanding and much needed protection for poor families. In addition, if Iowa's waiver were to be granted HHS would be setting a terrible precedent, and we are concerned that numerous other states might follow in Iowa's footsteps to the detriment of families across the country. Experience already shows that premiums decrease enrollment of very low-income beneficiaries, allowing monthly premiums for people with incomes below the poverty line will almost certainly result in current Iowacare enrollees losing coverage, and will cause newly eligible adults to drop coverage or not enroll at all. Charging premiums to Medicaid beneficiaries has been shown to result in steep losses of coverage. Wisconsin has been charging premiums at three percent of income to parents and caretaker relatives with incomes between 133 and 150 percent of the poverty level, and recent data shows a steep drop in enrollment. Data from the Wisconsin Department of Health Services' preliminary evaluation show that in the first six months of these premiums, slightly more than two-fifths of relevant enrollees lost coverage due to non-payment of a premium. A decade ago, Oregon imposed premiums on adults below poverty that ranged from $6 per month for people with no income to $20 per month for people at the poverty line. In the nine months that followed the increase, nearly half of those that had been on the program were no longer enrolled and the majority of them were left without coverage.	

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	These results should come as no surprise. People whose income is below the poverty level cannot afford to meet basic needs, and now allowing the Medicaid program to charge them premiums will be an insupportable burden, leading to a loss of health coverage, poorer health outcomes, and making it even ****** for them to escape from poverty. We urge you to reject Iowa's request to charge premiums to people with income below the poverty level. Thanks you for your consideration of our comments. Sincerely, Hugh Espey Executive Director Iowa Citizens for Community Improvement	
Olmstead-related issues to consider	The Iowa Olmstead Consumer Taskforce applauds the Governor and the Legislature for coming to agreement on the Iowa Health and Wellness Plan, but has significant concerns. (1) The importance of non-emergency medical transportation to accessing health care is well known, with ample research demonstrating that lack of transportation reduces use of preventive and primary care; on the other hand, research shows that access to transportation results in decreased use of emergency room services. The request for a waiver of NEMT transportation requirements thus undermines Iowa's stated goals realted to wellness and prevention. (2) The Taskforce strongly recommends that Medicaid eligbility be retroactive to three months, which would be consistent with the stated goal of minimizing out-of-pocket expenses for Iowans with limited income. (3) We understand that the purpose of the proposed premiums is to incentivize participation in wellness and prevention activities, but individuals below 138% of federal porverty level are at risk of all the disadvantages of poverty, from lack of transportation and child care to constraints in work schedules. We urge disapproval of any exception to Iowa regarding the charging of premiums.	2013-09-24 10:04
Child and Family Policy Center's Comments on Iowa Wellness Plan	In reviewing the Iowa Wellness Plan (IWP) waiver, there are four elements, in particular, that CFPC recommends be changed prior to submission: 1. Non-emergency transportation: Federal law requires Medicaid to cover non-emergency transportation. Providing non-emergency transportation services makes it possible for individuals to participate in services that improve or stabilize health, including preventive and health maintenance services. The waiver application does not offer any hypotheses for why eliminating non-emergency transportation will improve health. Section 1115 demonstrations are designed to test new strategies that improve health, not receive waivers from current requirements that have demonstrated effectiveness in improving health. 2. Co-payments for non-emergency room use of emergency room care: Iowa currently requires a $3 co-payment for non-emergent use of the emergency department. The IWP proposal calls for a $10 copayment for non-emergency use of the emergency department, which exceeds the federal maximum copayment of $8. While the actual difference between an $8 and $10 co-payment is likely to be trivial, there is no justification provided for seeking a waiver in this area – particularly as CMS has indicated it has no discretion in granting it.	2013-09-19 11:55

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	3. EPSDT services for 19 to 21 year-olds: Again, federal law requires that there be EPSDT services for 19 to 21 year-olds. Failing to provide EPSDT services for this age group could delay the diagnosis and treatment of mental illness, as many mental illnesses manifest when individuals are in this age range (19-21 years old). While such EPSDT services are not part of the essential benefits for the Marketplace plans, these services should be provided to those who are 19 to 21 who require them, even if this requires some kind of wrap-around coverage for the provision of that service, similar to what is being provided for dental care. 4. Retroactive eligibility for services: While in the future, with the Marketplace, there should be far fewer individuals who become enrolled in Iowa Health and Wellness Plan at the time of a specific medical event (often hospitalization or emergency room use), there still will be some individuals who will come to the attention of the system and can be enrolled at that time. Provisions are needed to ensure that, in these instances, individuals are covered at least as a bridge by the existing Medicaid program or the Iowa Health Wellness Plan. CFPC has significant concerns over the imposition of monthly payments for individuals below 100 percent of the federal poverty level. Even though the proposal explicitly states that the maximum monthly financial contribution, or premium, will not exceed 3 percent of household income, this provision is still in opposition to federal law and regulations. The Medicaid program allows for "nominal cost-sharing" that cannot exceed 5 percent of income, but also prohibits assessing premiums to individuals with incomes below 150 percent of poverty. There is a clear and significant difference between premiums and cost-sharing. Cost-sharing refers to a payment made to obtain services (e.g. copayment), whereas premiums refer to payments made to obtain coverage. The monthly contributions referred to in the waiver clearly falls under the premium category, and therefore are not permissible for individuals under 150 percent of poverty without a waiver. CMS has indicated that it does not anticipate providing a waiver in this area below 100 percent of poverty. We encourage other options to premiums in lieu of premiums for persons below 100 percent of poverty, also recognizing that the premium language at 50 percent of poverty is a feature of current state law. We also note that state law could be changed during the next session prior to any implementation of premiums (which would not effectively start until 2015). In addition to being prohibited by current Medicaid regulations, previous experience in the state of Iowa has demonstrated several negative consequences of imposing premiums on this population. During its first year of implementation, IowaCare imposed premiums on individuals with incomes below 100 percent of poverty. The imposition of premiums on this population produced significant hardship and disenrollment, leading Iowa to eliminate this requirement after only its first year of practice. An excellent feature of the demonstration is that these monthly payments are not imposed in the first year, but only in subsequent years and only when the individual has not undertaken some activity to promote the individual's health.	

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	There are few specifics in the posted 1115 demonstrations regarding the waivable premiums. CFPC recommends the following additional provisions be added to the proposal: 1. Set very simple standards for demonstrating the individual has engaged in health improvement practices, based initially upon a review of claims data. 2. Establish an alternative means for meeting the requirement through individual reporting of activities or behavior changes. 3. Notify individuals who have not yet met the requirement on a regular basis of their need to do so, starting at least six months before their renewal period, so they can schedule activities or take action to do so. 4. Provide extensions for individuals who have scheduled qualifying activities (such as a physical examination appointment) within the initial twelve month period, even if the appointment has not yet occurred. 5. Simplify the premium structure to a $10 monthly contribution for those below 100 percent of poverty and a $20 month contribution (as it is in the posting) for those between 100 and 138 percent of poverty. 6. Before initiating monthly contributions, review the claims records to determine if any individuals may qualify under the "medically frail" category and make changes to their status, as appropriate. 7. Include in the research and evaluation activities related to the 1115 demonstration specific follow-up reviews and studies of those individuals who do not meet the above requirements and become subject to monthly contributions. On issues of transparency, informed choice, and due process, there will be need to be substantially more outreach and explanation of options to those enrolling than currently exists under the standard Medicaid program. In particular, individuals will have to be fully informed of what constitutes being "medically frail" and what the difference in coverage is for those who qualify as "medically frail" if they accept either of the two new plans. In addition, particularly since the "medically frail" will include individuals who have frailties but generally do not use medical services except in times of emergency, reviewing claims data should not be used as a primary means of determining their "frailty" but should only be employed in identifying individuals for whom additional assessments may be warranted. There will need to be additional detail provided regarding the appeals and review processes related to all populations covered under the demonstration projects, with particular attention to ensuring that those who are designated (or might be designated) as "medically frail" have full information about, access to, and support to ensure their rights. The two 1115 demonstrations Iowa is submitting to cover adults under 138 percent of poverty would essentially create two additional public programs (the Iowa Wellness Plan and the Iowa Marketplace Choice Plan) in addition to the two existing Medicaid programs (the standard Medicaid program and the Health Insurance Premium Payment (HIPP) program for eligible individuals with employer-sponsored insurance). Operating these four programs and monitoring eligibility status that is dependent upon income, health status, and availability of employer-sponsored insurance will be a significant and complex administrative challenge. This process is extremely complex and will require significant and continuous outreach, education,	

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	and procedural safeguards to ensure that eligible individuals obtain the coverage and services to which they are entitled and that the federal Medicaid program requires that they receive. Adopting a continuous eligibility process (with the beneficiary's right to request a change) is one, simple change that could be made, not only to help individuals obtain and maintain coverage, but also to increase efficiency and reduce administrative burden. While the federal match rate for provision of care is 100% for the first three years of Medicaid expansion (and at least 90% thereafter), the federal match rate for administrative expenses is only 50-74%. It is in the state's fiscal interest to make administering this program as simple and efficient as possible. With respect to implementation of this new system, there should be research and hypothesis testing regarding the efficiency and effectiveness of this more complex system in relation to a simple expansion of the standard Medicaid program. This testing should include weighing the additional administrative costs and burden, as well as implications to enrollment and use of services and the costs thereof. This is an abbreviated version of our comments, full comments will be sent directly to CMS and can be obtained by contacting Charles Bruner (cbruner@cfpciowa.org) or Mary Nelle Trefz (mnt@cfpciowa.org).	
Iowa Coalition of Health Advocates' Group Comments on the Iowa Wellness Plan	Comments on Iowa Health and Wellness Plan Waiver Application: September 6, 2013 We would like to commend the efforts of all involved in working toward the development and successful implementation of an Iowa Health and Wellness Plan that provides high-quality healthcare services to Iowa's low-income population and assures cost-effective coverage opportunities for all Iowans. We would like to take this opportunity to recommend changes to several specific provisions within the "Iowa Wellness Plan". These changes should be made to meet the requirements of a demonstration project and to achieve the health goals for the population that is to be served by the program. We would also like to voice the importance of transparency and open discussion in articulating and developing the numerous programmatic details and definitions that must be occur prior to the implementation of the program. The four areas of concern are as follows: 1. The coverage of transportation expenses for non-emergency transportation. Federal law requires Medicaid to cover non-emergency transportation. Evidence and experience demonstrate that providing non-emergency transportation allows individuals to participate in non-emergency medical visits (including preventive and health maintenance services) and ensures the use of services that improve or stabilize health. Section 1115 demonstrations are designed to test strategies to expand coverage, expand eligibility, or test innovative delivery systems that improve care, increase efficiency, and reduce costs. No hypotheses are offered as to how eliminating these services would meet any of these demonstration strategies. 2. The provision of EPSDT services for 19-21 year-olds. Federal law requires that EPSDT services must be available for 19-21 year-olds. Failing to provide EPSDT services for this age group could delay the	2013-09-18 07:22

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	diagnosis and treatment of mental illness, as many mental illnesses manifest when individuals are in this age range (19-21 years old). 3. The provision for retroactive eligibility for coverage. The section application proposes ending the current Medicaid provision of retroactive eligibility. Under current Medicaid provisions, individuals are eligible for coverage at the time of their application and Medicaid can even be billed for some services the individual received prior to enrollment. While the overall expansion and opportunities to enroll in the months preceding January 1, 2014 should mean that many individuals effectively will be enrolled at the time they are eligible, there still will be instances where individuals may need to become enrolled at the time of a specific medical event (often a hospitalization). Ending retroactive eligibility would mean that, in these instances, the hospitals, emergency rooms, or individuals would bear these immediate costs. 4. The provision for maximum emergency room cost-sharing for non-emergent care. The maximum required copayment for non-emergency use of the emergency room, as set by federal law, is $8. The Iowa demonstration proposal, however, calls for a $10 copayment. While the actual difference between an $8 and a $10 dollar copayment is small, there is no justification provided for seeking a waiver in this area. CMS has indicated that it does not have the authority to waive any cost-sharing limitations with a section 1115 waiver. In addition to these four provisions, we have significant concerns over the imposition of monthly payments for individuals below 100 percent of the federal poverty level. Federal regulations prohibit assessing premiums on individuals with incomes below 150% of poverty. IowaCare imposed premiums on individuals below 100% of poverty during its first year of implementation. However, imposing premiums on this population led to significant hardship and disenrollment. As a result, this requirement was eliminated after only its first year of practice. Tying this requirement to compliance with yet to be determined “key activities” could also create significant administrative burden. Further, there is nothing in the research and hypothesis testing portion of the application that speaks to examining the potential adverse impacts of the premium requirement on individuals. We would urge examining ways that the Healthy Iowa Plan can achieve its goals of promoting wellness (primarily through incentives) without imposing monthly contributions. Implementing the Iowa Wellness Plan will require a great deal of detailed planning work and complex implementation strategies. There are several areas which are not specifically addressed in the demonstrations that should be areas for future discussions: 1. Provisions for education and outreach of those who may be eligible so they can make informed choices, including deciding whether to go into the standard Medicaid program or the Healthy Iowa Plan. 2. Provisions for appeal and due process in all aspects of the process of securing and maintaining coverage. 3. Provisions for determining what constitutes a “medically frail” individual. 4. Provisions for determining when monthly premiums are waived.	

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	5. Assurances that family planning services are covered and that federal qualified health centers are provided full and fair reimbursement. 6. How the different provisions for which a waiver is required will be subject to evaluation and, in particular, to looking for any negative consequences to individuals. We are confident that the waiver can be amended to address all these areas of concern. We are also confident that with continued open discussion, cooperation, coordination, and a lot of hard work, the technical and logistical challenges of implementation will be addressed. Brain Injury Alliance of Iowa Easter Seals of Iowa Epilepsy Foundation of North Central Illinois, Iowa, and Nebraska Family Planning Council of Iowa Iowa Mental Health Planning Council Iowa Association of Area Agencies on Aging Iowa Community Action Association Iowa Developmental Disabilities Council Iowa Federation of Labor, AFL-CIO Iowa Primary Care Association Iowa Psychological Association League of Women Voters of Iowa Leukemia, Lymphoma Society, Iowa Chapter National Alliance on Mental Illness of Greater Des Moines National Association of Social Workers, Iowa Chapter Planned Parenthood of the Heartland Polk County Health Services	
Federal budget neutrality cannot be met.	7. The requirement of federal budget neutrality cannot be met. The Iowa proposal which involves premium assistance will cost more for the federal government than just expanding Medicaid. Administratively and for overall cost, 3 programs cost more than 1 program to serve the same population – it will include the administrative cost of handling the movement of persons among 5 programs and the tracking of health and wellness activities to justify no premium cost – a burdensome process for providers and for Medicaid personnel. In reviewing previous financial documents based on Milliman reports, total federal funds needed for the Exchange premium subsidy for only the 101% - 138% population was $442,768,339 in FY 2015. Why is this version only indicating $200 to $230 million? The total federal cost if straight Medicaid expansion was chosen for all up to 138% was $576,700,000 in FY 2015.	2013-09-16 11:12
Persons in community corrections should be eligible.	4. There is no reference to the eligibility of persons in community corrections. Persons in community corrections are often in health care limbo - the Dept. of Corrections does not pay for health care since they are technically ex-offenders – eligibility for Medicaid not possible because the interpretation is that they are still in the corrections system, and the county often does not have the funds available to pay either. People in community corrections need health care to help	2013-09-16 11:10

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	reduce recidivism and to lower corrections costs. Including persons in a version of Medicaid expansion will improve health outcomes	
Retroactive eligibility should be mandatory.	3. Retroactive eligibility should be mandatory for all programs. Current Medicaid Iowa policy is to allow backdating of Medicaid eligibility for up to 3 months. To forbid backdating will open up excessive financial liability to extremely low income persons if coverage is not obtained until the 1st day of the following month when eligibility is determined. The proposed policy waiver will perpetuate medical bankruptcies. Hospitals and emergency rooms would bear these immediate costs. To not allow retroactive eligibility will be a detriment to care, it will decrease efficiencies, and will cause an increase of costs for a medical event for all concerned, not a reduction.	2013-09-16 11:09
EPSDT services must be available for 19-21 year olds.	Federal law requires that EPSDT services must be available for 19-21 year olds. Failing to provide EPSDT services for this age group could delay the diagnosis and treatment of mental illness, as many mental illnesses manifest when individuals are in this age range (19-21 years old). To deny EPSDT services does not improve health outcomes.	2013-09-16 11:07
Transportation is a necessary benefit which should be added.	4. Transportation is a necessary benefit to be included for this population. Federal law requires Medicaid to cover non-emergency transportation. Medicaid dollars are being used in both the IHWP and Marketplace Choice plans. Studies in Iowa have proven transportation is cost effective. It minimizes the number of missed appointments by more than 50%. The Iowa Medicaid program already has a transportation assistance program in place and could be amended to accommodate the new population. Section 1115 demonstrations are designed to test strategies to expand coverage, expand eligibility or test innovative delivery systems that improve care, increase efficiency and reduce costs. No hypotheses are offered as to how eliminating these services would meet any of these demonstration strategies.	2013-09-16 11:05
Monthly premiums are not acceptable and have proved detrimental in the past.	1. Monthly premiums (contributions) are not allowable according to ACA and Medicaid expansion rules for persons with incomes less than 150% of FPL. In the waiver population, 138% of federal poverty level translates to an hourly wage of $7.62 – barely above the federal minimum wage rate of $7.25 – hardly a flush financial circumstance where premiums can be afforded. In addition to being prohibited by current Medicaid regulations, previous experience in the state of Iowa has demonstrated several negative consequences of imposing premiums on this population. During its first year of implementation, Iowa Care imposed premiums on individuals with incomes below 100% of poverty. The imposition of premiums on this population produced significant hardship and disenrollment, leading Iowa to eliminate this requirement after only its first year of practice. Why would we hit our heads against a brick wall again and expect different results? Iowa Care covers people up to 200% of FPL and there was significant hardship and disenrollment to premiums. The Iowa Wellness Plan covers people up to 100% of FPL. The Market Place Choice Plan covers people at 101% to 138% of FPL.	2013-09-16 11:04

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	In a review of research, even among individuals with substantial means, the use of incentives or sanctions through health insurance coverage can only do so much to support behavior changes and adoption of more healthy regimens. These are most likely to be successful for relatively simple and straightforward actions, such as obtaining a flu shot or having an annual physical examination. There is no definition of what preventative services will include. For individuals terminated from the Iowa Wellness Plan for nonpayment of required contributions – they must then reapply for the Iowa Wellness Plan and go through the eligibility process again to receive coverage. Will terminated persons also have to pay past premiums current in order to be re-enrolled? How far will the hardship waiver reach? Once again, health outcomes will improve – but not because of monthly premiums or because monthly premiums are forgiven – it will be because health insurance will finally be available to the expansion population.	
Public comments represented thousands of people.	3. Did HHS/CMS receive copies of the actual public comments? To the reader of the waiver applications, it appears there were few comments made – 13 is the maximum number in the narrative. Actually the comments submitted were on behalf of multiple organizations – in some cases, up to 30 organizations – which represent thousands of people. • AARP • Health Advocates • NAMI Iowa • NAMI Greater Des Moines • AMOS (A Mid Iowa Organizing Strategy) • Iowa Mental Health Planning Council • Access for Special Kids (ASK) Resource Center • Brain Injury Alliance of Iowa • Easter Seals of Iowa • Child and Family Policy center • Epilepsy Foundation of North Central Illinois, Iowa, Nebraska • Family Planning Council of Iowa • Iowa Alliance for Retired Americans • Iowa Association of Area Agencies on Aging • Iowa Citizen Action Network • Iowa Community Action Association • Iowa Developmental Disabilities Council • Iowa Nurses Association • Iowa Olmstead Task Force • Iowa Primary Care Association • Iowa Psychological Association • Iowa Statewide Independent Living Council • League of Women Voters of Iowa • Leukemia and Lymphoma Society, Iowa Chapter • National Association of Social Workers, Iowa Chapter	2013-09-16 11:02

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	• National Multiple Sclerosis Society, Upper Midwest Chapter • Planned Parenthood of the Heartland • Polk County Health Services • Visiting Nurse Services of Iowa • And others	
Medicaid rules and benefits should follow the use of Medicaid dollars.	1. Medicaid expansion dollars are being used to pay for the Iowa Health and Wellness Plan and for the premiums in the Marketplace Choice plan – shouldn't the Medicaid rules follow along with the Medicaid dollars- aren't they one and the same?	2013-09-16 11:00