Section 1115 Eligibility and Coverage Demonstration Implementation Plan: Healthy Behaviors Program Protocol for the Iowa Wellness Plan

Overview: Iowa's Healthy Behaviors Program is designed to influence how consumers interact with their health care system, emphasizing primary care access and utilization. The Healthy Behaviors Program is designed to reward members through encouraging completion of healthy behaviors by rewarding them with waiver of contributions (premiums) in subsequent enrollment periods.

Stakeholder Engagement in Protocol Development

Iowa began engaging stakeholder input for the Iowa Health and Wellness Plan by holding public hearings and education sessions prior to implementation. Each hearing included initial details regarding the Healthy Behaviors Program, with the specific activities added into the discussion once finalized. Two public hearings were held in July 2013. Thereafter, another six public hearings were held statewide in conjunction with the State Innovation Model grant outreach. Each session was attended by a variety of community members, providers and stakeholder organizations.

Iowa has also undertaken an extensive and comprehensive stakeholder approach as part of the State Innovation Model (SIM) Design Grant project in the summer and fall of 2013. A broad spectrum of stakeholders were involved, including providers, payers, physicians, practitioners, managed care organizations, and state agencies like Iowa Department of Public Health and Iowa Department on Aging.

Iowa also sought consumer input through two specific Consumer Focused workgroups and a series of public meetings called Listening Sessions. One workgroup was tasked with identifying goals and approaches to engaging members in their own health care and encouraging them to be active participants in becoming healthier. All workgroups discussed the importance of member engagement strategies and specifically the Healthy Behaviors Program for the Iowa Health and Wellness Program.

The SIM stakeholder process, a list of stakeholder participants, meeting agendas, meeting minutes, workgroup summaries and the State Healthcare Innovation Plan are all available at: https://dhs.iowa.gov/ime/about/initiatives/newSIMhome.

Iowa also sought input from the Patient-Centered Health Advisory Council and presented the 2014 Healthy Behavior Program for Iowa Health and Wellness Plan at the November 15, 2013 meeting.

Additional stakeholder feedback has been received throughout the fall of 2013 with a variety of organizations. A special meeting of the Medical Assistance Advisory Council (MAAC) was held on August 15, 2013. This session focused on details on the Iowa Health and Wellness Plan, and included a discussion on the Healthy Behavior programs. On November 21, 2013, the Healthy Behaviors were again discussed with the full MAAC membership. The meeting was open to the public. The Healthy

Behaviors, including member outreach and education, was a key topic of the MAAC Executive Committee meeting in April 2014, and the full council meeting in May 2014.

Other key stakeholder organizations have held meetings on the Iowa Health and Wellness Plan, all meetings including discussion of the Healthy Behaviors Program. Some of the organizations include:

- Iowa Hospital Association
- Iowa Mental Health Planning Council
- Epilepsy Foundation
- Coalition for Family and Children's Services
- Iowa Behavioral Health Association
- Iowa Primary Care Association
- Visiting Nurse Services of Iowa
- Iowa Safety Net Providers
- Iowa State Association of Counties
- Susan G. Komen Foundation, Iowa Chapter
- Family Development and Self Sufficiency Program
- Iowa Rural Health Association
- AmeriCorps

Further, Iowa accepted written comments from the Child and Family Policy Center. Specifically related to the HRA requirement, the IME decided to use the HYH tool after meeting with various stakeholders including the following:

- Coventry Health Care of Iowa — November 26,2013
- CoOportunity Health — December 5, 2013
- University of Iowa Public Policy Center — December 6, 2013
- The University of Iowa Alliance — December 17, 2013
- UnityPoint Health — December 19, 2013
- Meridian Health Plan — December 19, 2013
- Treo Solutions — December 24, 2013

From the stakeholders who are provider entities, the IME learned that, if the entity uses an HRA, it is to gauge their members' health status and to subsequently implement incentives to encourage healthier behaviors with the long-term goal of reducing health care costs.

The University of Iowa Public Policy Center provided HRA research consistent with the information presented by the provider entities. The research showed that HRA are helpful to engage patients in their care and help primary care practices and patients work in close cooperation. Additionally, the IME found that HRAs have been widely used in employer sponsored plan for a number of years as a means to control costs.

Contribution Waiver for Healthy Behaviors Program

Iowa has designated completion of a Health Risk Assessment (HRA) and a wellness exam as the healthy behaviors that will qualify members for waiver of their contributions in their subsequent enrollment period. There are no contributions charged for the first year of enrollment.

Healthy Behavior 1: Completion of a HRA

In an effort to improve patient outcomes and engage members in their health care, the Managed Care Organizations (MCOs) have developed HRAs. The HRAs include questions regarding hospital visits, chronic diseases, and social determinants of health. The HRA can be completed by mail, fax, online, or by phone to the MCO. The MCOs are required to conduct a comprehensive assessment if a special health care need is identified in the HRA. The MCOs help the member set up appointments with a primary care provider if needed.

Healthy Behavior 2: Completion of a Wellness Exam

Members are encouraged to complete an annual preventive wellness exam or a dental exam as part of an emphasis on pro-active healthcare management. Wellness exam have been defined by the following codes:

New Patient CPT Codes		Established Patient CPT Codes	
99385	18-39 years of age	99395	18-39 years of age
99386	40-64 years of age	99396	40-64 years of age

Dental examination codes that can also meet the requirements of a wellness exam are:

Code	Description
D0120	Periodic Oral Evaluation
D0140	Limited Oral Examination
D0150	Comprehensive Oral Examination
D0180	Comprehensive Periodontal Exam

As mentioned above, IME will ensure members who have completed their healthy behaviors are not charged contributions in their second year of enrollment. IME receives files from the MCOs to update the IME system that the healthy behaviors have been completed and this will be reported through the Quarterly Progress reports. Members will be given their first enrollment year and an additional 30-day grace period to qualify to have their contributions waived in their subsequent enrollment year. During this grace period, members will also be given the opportunity to self-report completion of the wellness exam.

Beneficiaries who are exempt from premiums are those who are medically exempt, Alaska Native/American Indian, and those in Health Insurance Premium Payment (HIPP). Women who are pregnant at the time of application or at the time of redetermination are placed in the Mothers and Children category for Medicaid. If a woman becomes pregnant while on the IWP and notifies the state of her pregnancy has

a choice of IWP or Medicaid. If a pregnant woman remains on IWP, the state has identified that pregnant women are not being excluded for premiums. The state will be updating programming to correct this.

If the member indicates on the application that they are American Indian/Alaska native, this then triggers the enrollment system to exclude them from premium payments. The member may also call in to member services to notify us of their race. Providers can also call in and share this information.

System programming in underway to capture and track when beneficiaries have reached the premiums aggregate cap (quarterly aggregate cap of 5 percent of household income) through the claim and contribution system. The system will provide reports on a monthly basis to identify when the 5% cap has been met. Should the programming not be in production when the waiver for collecting contributions expires at the end of the public health emergency, a manual backup plan is being outlined.

Premium/Contribution Protocols

During their first year of eligibility, all members will be exempt from any contribution payments. This will permit the member the opportunity to 1) gain an understanding of the Healthy Behaviors Program and 2) to complete those Healthy Behaviors that will qualify the member for contribution waiver in the second year of eligibility. In each enrollment year that the member completes the Healthy Behaviors, the member will qualify to have their contributions waived in the subsequent year.

Regardless of whether they complete their Healthy Behaviors, the following members will be exempt from contribution payments:

- Persons with income at or below 50 percent the Federal Poverty Level (FPL)
- Persons with a Medically Exempt (Medically Frail) status
- American Indians/Alaska Natives
- Health Insurance Premium Payment (HIPP) enrollees

Members who do not complete their Healthy Behaviors during the first year of enrollment will be subject to the contribution payments in their second year of enrollment. Contributions will be charged as follows:

- Persons with income >50–100 percent of the FPL = $5 monthly contribution
- Persons with income from >100-133 percent of FPL = $10 monthly contribution

The IME will give members a 30 day grace period after their enrollment year to complete their Healthy Behaviors and qualify for contribution waiver. After that time, if the member has not qualified for contribution waiver, the IME will begin sending monthly billing statements including a hardship exemption request form. The billing statement will be mailed to the member prior to the first day of the month in which the contribution is due. Members will have until the last day of the contribution month to either mail in their contribution or request a hardship exemption for the month. Members may pay by check,

money order or online through the IME Click Pay site. Directions of where to mail the contribution, how to request a hardship exemption, and who to call with questions will be clearly detailed on the billing statement. A hardship exemption can be requested by checking the hardship exemption on the billing statement or by calling the IME. No documentation is needed to claim a hardship exemption. Unpaid contributions will be reflected on the member's next monthly billing statement.

For individuals at or below 100% FPL, unpaid contributions will not, however, result in termination from the Iowa Wellness Plan.

For members with income over 100% FPL, if a member fails to pay any monthly contributions after a 90 day grace period, the IME will terminate the member's enrollment status. The member's outstanding contribution will be considered a collectible debt and subject to recovery. A member whose benefits are terminated for nonpayment of monthly contributions must reapply for Medicaid coverage. The IME will permit the member to reapply at any time, however, the member's outstanding contribution payments will remain subject to recovery.

After the 90 day grace period, unpaid premiums may be considered a collectible debt owed to the State of Iowa and, at state option, subject to collection by the state, with the following exception: If, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment, unpaid premiums shall not be considered a collectible debt by the state.

Year Two and Subsequent Years

If the member completed the healthy behaviors listed above, then the contribution is waived for the second year. The member must complete the healthy behaviors in year two and subsequent years to have the contribution waived in the next enrollment year.

Systems Monitoring

Information collected on the HRA assess a member's physical, behavioral, social, functional, and psychological status and needs. It determines the need for care coordination, behavioral health services, or any other health or community services. The HRA complies with the NCQA standards for health risk screenings.

If the HRA identifies a special health care need is identified the member is referred to non-waiver case management. The member is then assessed using a complex care/comprehensive care assessment. Case management is explained to the member and those who consent are place in the case management program.

The IME Medicaid Management Information System (MMIS) has been coded to detect all persons who are mandatorily exempt. The MMIS is also coded to capture those members who complete both a wellness exam and an HRA during a twelve month period of continuous enrollment in the IWP. Ensuring a member has twelve months of continuous enrollment prior to being subject to monthly

contributions will avoid any unintended harm to the member if the member's coverage options change periodically (aka churn). For example, there may be situations wherein the member loses IWP eligibility if they become eligible for another Medicaid program, gain access to employer sponsored insurance (ESI), or their economic situation improves such that they can access insurance through the Health Insurance Marketplace. If the member churns back to the IWP, the MMIS system will detect that the member had a break in coverage and has not had twelve months of continuous coverage in the IWP and will therefore not be subject to monthly contributions. Essentially, a break in the member's coverage will begin a new twelve month period during which the member will be exempt from contributions. See the examples below:

Example: Member A

- 01.01.19 enrolled in IWP
- 07.01.19 gains access to ESI and is disenrolled from IWP
- 09.01.19 loses access to ESI, applies for Medicaid and is determined eligible for IWP.

Member A did not have 12 months of continuous IWP eligibility. Member A will be exempt from monthly contributions during his enrollment period that begins 09.01.19. Member A will have 12 full months to complete a wellness exam and HRA to continue to be exempt from monthly contributions in the next enrollment year.

Example: Member B

- 01.01.18 enrolled in IWP
- 12.31.18 Member B does not complete healthy behaviors; at re-enrollment she is determined eligible for Mothers and Children (MAC) program
- 01.01.19 – 12.31.19 Member B has MAC coverage
- 01.01.20 Re-enrollment determines Member B is eligible IWP.

Although Member B had 12 months of IWP coverage, there has been a 12 month break in that coverage. Member B will be exempt from monthly contributions and have 12 full months to complete a wellness exam and HRA to continue to be exempt from monthly contributions in the next enrollment year.

Information collected on the HRA assess a member's physical, behavioral, social, functional, and psychological status and needs. It determines the need for care coordination, behavioral health services, or any other health or community services. The HRA complies with the NCQA standards for health risk screenings.

If the HRA identifies a special health care need is identified the member is referred to non-waiver case management. The member is then assessed using a complex

care/comprehensive care assessment. Case management is explained to the member and those who consent are place in the case management program.

Managed Care Organizations (MCOs) are provided flexibility in methods for monitoring healthy behaviors at the provider level, including standards of accountability for providers. For example, one MCO provides access to completed HRA data via its provider portal and providers are educated on their accountability for accessing this assessment and working to improve these unhealthy behaviors during their annual wellness exam and any follow up visits as necessary. Additionally, many providers are engaged in value-based contracts which incentivize quality performance through meeting established metrics around HEDIS data, which focuses heavily on preventive care for members in alignment with the Healthy Behavior requirements.

Medically Exempt

Individuals who otherwise qualify for IWP but who need specialized medical services due to complex medical conditions or mental, physical or developmental disorders will be eligible for more comprehensive coverage through Iowa's traditional Medicaid program. This is referred to as being Medically Exempt.

Iowa uses the term 'Medically Exempt' to define the Federal definition of 'Medically Frail'. 'Medically Frail' includes: individuals with disabling mental disorders (including adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria.

Members or their providers can complete a survey either by phone, fax or mail for the IME to determine if the member meets the definition of Medically Exempt. If the member is Medically Exempt, the member will have the full Medicaid benefits the next month after determination. More information and the survey instrument can be found at: https://dhs.iowa.gov/sites/default/files/Medically%20Exempt%20Toolkit.pdf?012220201532.

Once a member becomes Medically Exempt, the member remains Medically Exempt for life for purposes of exemption from premium requirements and enrollment in State Plan benefits.

Debt Collection

The IME has initiated a debt collection process. The state has a premium payment system that tracks all invoices, payments and non-payments. When an IWP member's premium becomes ninety (90) days past due and the amount owed is $50 or greater, the debt collection is sent to the Iowa Department of Revenue (IDR). IDR then attempts to collect the amount using various methods such as establishing a repayment plan or taking monies from a tax refund. This debt is not reported to credit agencies.

Disenrollment

Before an IWP is disenrolled, the members have received invoice statements that state they may be disenrolled if the contribution is not paid for 90 days. Each invoice includes the months for which the member owes a contribution.

As occurs for all Medicaid eligibility terminations, prior to disenrolling an individual for premium non-payment, the eligibility system conducts an automated determination to confirm whether the individual is eligible for another Medicaid category.

When an IWP member is disenrolled from IWP, the member can reapply for IWP at any time. If the member reapplies in the month of the disenrollment and is eligible for the plan, there would not be a gap in coverage. If the member reapplies after the month of disenrollment and is found eligible for the plan, enrollment would begin the month of the application date.

Appeal Process

A member can appeal the disenrollment from IWP when the contribution is 90 days past due, the amount of the contribution or benefits. The appeal process is the same for IWP as it is for Medicaid. During the appeal process, a member can continue benefits while awaiting the outcome of the appeal. If the member loses the appeal, the member will be responsible for any claims or capitation payments made during that time.

The Quarterly Progress Reports will detail the number and types of appeal received during the reporting quarter.

Communication

Communication about IWP can begin before a person becomes eligible for IWP. The Department's website has a page about IWP at https://dhs.iowa.gov/IHAWP. The page includes information about:

- Who qualifies
- Benefits
- Health Plans
- Healthy Behaviors
- How to Apply
- Find a Provider
- Resources
- Frequently Asked Questions
- Rights and Responsibilities

All mailings are distributed state wide and are available on the Department's website. The website page also tells current members how to make their contribution online or the address to send the payment if they choose not to pay online.

Beneficiaries can report changes by phone, email, fax, or in person. These methods are included in Communication 233, Rights and Responsibilities, which is included in the application form.

Also, the form 'Ten-Day Report of Change for Medicaid/Hawki is available on the DHS website as well as in the Self-Service Portal (SSP). This form also provides the methods for reporting changes. Contact information for the department is also available on the website. Details about the Iowa Wellness Plan are included in both the IA Health Link Member Handbook and the Fee-for-Service Member Handbook. These details include an overview of the program, covered benefits, Healthy Behaviors requirements and information about monthly contributions.

Both the IA Health Link and Fee-for-Service member handbooks are available on the DHS website in both English and Spanish. Should a member need information in another language, they can use the state's Interpreter Services by calling Iowa Medicaid Member Services.

A flyer with information about how to access the member handbook is included in the welcome packet that is mailed to new Medicaid enrollees.

The IME utilizes computer software to determine the reading level of all communication sent to members.

If the member has not completed the healthy behavior activities two months prior to the end of the member's first enrollment period, the MCOs send a notice to the member about completing these healthy behaviors. The notice is member specific, telling the member which or both healthy behaviors still need to be met to qualify for the exemption of contributions.

IWP members in their second and subsequent years who did not complete the healthy behaviors during the prior enrollment period are sent an invoice on the first of each month. The invoice tells them when their contribution is due, how to pay the contribution either online or by mail, how to claim a financial hardship and the consequences for not paying the contribution each month.

New information about IWP is communicated through the Department's website, Medicaid e-news, newsletters and direct letters to IWP members.

Beneficiaries are notified by mail of any changes in requirements. For example, if the payment amount is recalculated, the beneficiary will receive a payment statement indicating the new payment amount. If other changes occur, the MCOs and the state work together to provide communication to beneficiaries.

The Notice of Action (NOA) regarding eligibility decisions are mailed to beneficiaries at the time the determination is made. If the determination results in negative action, the NOA is mailed allowing for timely notice of at least ten calendar days.

At any time, a potential member or an eligible member can call or email Medicaid Member Services to get answers to their questions or help to solve any issues with IWP.

The MCOs are required in their contract with the IME to have member and provider incentives in place to increase quality outcomes, encourage utilization of health services and healthy behaviors. The IME is collaborating with the MCOs to further address communication about the completion of healthy behaviors through providers and members.