Iowa Health and Wellness Plan Process Evaluation Report

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Executive Summary

General IHAWP

In January and February of 2022, 14 key stakeholders involved in the administration of Iowa Medicaid's Iowa Health and Wellness Plan were interviewed via phone. Three main types of Iowa Health and Wellness Plan stakeholders were represented by interviewees, including 1) Managed Care Organizations, 2) Provider Associations, and 3) Iowa Medicaid. Key stakeholders shared comments about the Iowa Health and Wellness Plan (IHAWP) program overall, outlined below:

Successes and Achievements

- Improved continuity and expanded access to healthcare coverage for more of the state's population

- Improved health outcomes for the IHAWP population

- Provided opportunities to identify members who meet eligibility requirements for the basic IHAWP and assess needs for potential inclusion in more expansive benefits via qualification for medically exempt status

NEMT and Transportation

- Respondents noted differing transportation benefits, which create a challenge not only for members to navigate, but also for caseworkers, who are responsible for assessing member barriers.

- Communication with IHAWP members about transportation benefits is portrayed alongside more comprehensive coverage plans which do include transportation. (Figure 6Figure 2)

- Interviewees shared various perceptions of the level of transportation need amongst IHAWP members. Representatives from both MCOs and Iowa Medicaid reported that unmet transportation needs were not an urgent issue for IHAWP members.

- In contrast to perceptions of a low prevalence of unmet transportation need voiced by some key stakeholders, an MCO representative described transportation as *"It's the number one [barrier]"* and linked the lack of transportation benefit to *"almost seven years of member frustration."*

- For members, a lack of direct, reliable, timely transportation to healthcare appointments diverts time and resources from work, caring for dependents.

- Members relying on informal or inadequate public transportation risk missing appointments, shortened appointments, or foregoing care completely.

Healthy Behaviors

- Across interviewees, there was consensus about the goals of Iowa's Healthy Behaviors Program, which included:
  - Engaging members in their health care
  - Promoting utilization of preventive (versus reactive) services

- o Connecting members to a primary care provider and

  - o Encouraging members' awareness of their own health status

- Interview respondents did not have substantive responses about whether HBI components and related efforts were directly associated with improvements in member health (through the use of preventive care or completion of a health risk assessment), but respondents indicated that the reasoning behind the incentivized requirements were valid.

- Interview respondents reported collaborative efforts in the form of workgroups and to promote alignment of HRA content across MCOs.

- Representatives from both MCOs shared perceptions of general alignment across HRAs administered within each of their managed care strategies.

- There was some uncertainty amongst stakeholders about whether the state maintained its own HRA (separate from the HRAs deployed by MCOs).

- Data uses reported by stakeholder included:

  - o Understand and respond to member needs at a population level

  - o Inform providers of population level issues and develop programming

  - o Inform individual member case management

  - o Quarterly waiver federal compliance reporting

  - o Establish a publicly available statewide data resource (under development)

- Interviewees discussed collaborative efforts across statewide stakeholders related to HBI, primarily focused on health risk assessment development and implementation.

- Key stakeholders reported added efforts undertaken to successfully implement and support the state's Healthy Behavior Incentive program, which include MCO-specific value-added benefit programs (includes incentives for HRA and annual wellness exam completion), provider education efforts, creative member communication, informing outreach to establish primary care connections with claims-based utilization data, and efforts to address Social Determinants of Health (SDH) needs identified in HRAs.

- Value-added benefit programs administered by the state's MCOs are independent initiatives from the state's Healthy Behavior Incentive program. (Figure 4)

- Stakeholders talked about efforts to inform members about the HBI program, from both Iowa Medicaid and MCOs, which together culminate to a mixed-method communication and reminder campaign, including messaging via:

  - o Member handbooks

  - o Mailed letters (occasional neon paper)

  - o Information posted to state and MCO websites

  - o Texting (cell phone)

  - o Phone calls

    - ▪ Incoming from case managers

- - Call center availability (outgoing from members)
  - o Flyers
  - o Postcards (occasional neon paper)
- While MCO representatives described overarching values of health equity and strategies to mitigate health disparities in other health outcomes, no efforts were reported specific to addressing the HBI program disparities.
- Dual wellness exam and HRA awareness promotion campaigns from the state and MCOs can be difficult to navigate.

Retroactive Eligibility

- Key stakeholders interviewed shared their understanding of the goals of the retroactive eligibility waiver in Iowa, which included the motivations listed below,
  - o Encouraging proactive member enrollment
  - o Response to fraud
  - o Program level financial solvency
  - o Ensuring timely eligibility determination by providers (regarding abbreviated time frame)
  - o Certifying that eligible beneficiaries receive coverage
  - o A mechanism for providers to be reimbursed for services rendered to uninsured people
  - o Timely documentation of enrollee utilization patterns (regarding abbreviated time frame)
  - o Promoting efficiency in the enrollment, care management, and reimbursement processes
  - o Provide a safety net for Medicaid-eligible uninsured people with a catastrophic health event
  - o Aligns enrollment window timeline (calendar month) with premium payments to MCOs
- Stakeholders shared perceptions of how effective the retroactive eligibility waiver policy is in achieving its various goals, with some highlighting positive impacts, acknowledging challenges in application, and noting low levels of awareness amongst members.
- Stakeholders shared perspectives about the Medicaid enrollment process within the scope of the retroactive eligibility waiver, noting the various roles and steps involved. Interviewees reported hospital-based advocates, MCO case managers, administrative positions, community health workers, hospital social workers, healthcare staff and socialized enrollment staff as having roles in guiding newly identified eligible members through the enrollment process and maintaining related records.
- A representative from Iowa Medicaid noted that typically, MCO case workers would be relied upon for care coordination tasks, but people in the process of applying for retroactive coverage do not have access to that support.

- Representatives from an MCO and provider association elaborated that the intention of retroactive eligibility waiver to encourage proactive enrollment amongst eligible populations may lack effectiveness due to a complex design, more immediate competing priorities, and a general lack of awareness of potential eligibility.

- A representative from a provider association discussed the role of providers and clinic staff in operationalizing retroactive eligibility, reporting that providers are burdened with additional administrative work to verify member eligibility and funding care at the time of service.

Cost Sharing

- Interviewees shared perceptions of the goals of cost sharing, mentioning the following intentions of soliciting a copay from members in the case of nonemergent ER use:
    - Deterring utilization of the emergency room for nonemergent complaints or routine care
    - Creating a point of intervention to educate members and direct them to more appropriate care settings
    - Promote awareness of healthcare costs to members and set the expectation to financially contribute to healthcare services (in alignment with private coverage)
    - Reduce emergency room provider burden

- Interviewees shared perceptions about the effectiveness of cost sharing and conveyed skepticism about its impact on emergency room use.

- Representatives from MCOs and provider associations compared the effectiveness of the cost sharing expectation to other efforts, favoring more tangible efficacy of member education.

- Perceptions of the validity of cost sharing as an emergency room deterrent were not widely supported, with interviewees unsure of evidence of effectiveness in practice or in research.

- Stakeholders doubted the impact of the $8 copay, suggesting the amount was too nominal to impact member decision-making or incentivize enforcement.

- Interviewees shared perceptions about whether a copay might interfere with necessary use of the emergency room, reporting that $8 was unlikely to cause financial strain or a barrier to needed care.

- Figure 5 shows the cost sharing process and various roles stakeholders have in implementation.

- A representative from Iowa Medicaid suggested that member utilization of emergency care is generally validated by providers, avoiding the imposition of a copay altogether.

- Regarding the motivation of providers to enforce cost sharing and solicit copays from members, stakeholders acknowledged wide recognition of inefficiency, noting that the nominal amount of money to collect is not worthwhile for providers.

- Stakeholders report in cases that members do not pay the copay at time of admission, providers absorb the copay charged to members rather than collecting payment via billing, a decision which could vary by hospital size.

- A provider association representative suggested that better tracking of payments and follow-through from providers would be needed to understand the effectiveness of cost sharing.

- Stakeholders talked about efforts which parallel or support the goals of cost sharing, including member education campaigns, case management, targeting high-utilizing emergency room (ER) members through claims and HRA data analysis, expansion of care access options, and alignment with value-based reimbursement models.

- Key stakeholders described interactions with members related to the administration of the cost sharing policy and levels of member awareness and engagement:
    o Limited awareness of copay
    o Reluctance to enforce copay or referral because of consequences of delayed or denied member care
    o Copay presents a potential financial stressor for low-resourced members

- Spillover effects of cost sharing implementation primarily impact providers (Figure 5)

Key Stakeholder Interview Results

Phone interviews were conducted with 14 key stakeholders involved in the administration of Iowa Medicaid's Iowa Health and Wellness Plan in January and February 2022. Interviewees represented three main types of Iowa Health and Wellness Plan stakeholders in Iowa, including 1) Managed Care Organizations, 2) Provider Associations, and 3) Iowa Medicaid.

Figure 1 displays the distribution of categorized content by type of key stakeholder interviewed. Interviews were conducted with representatives from both Managed Care Organizations in the state, two statewide provider associations, and the state Medicaid agency, Iowa Medicaid (formerly known as Iowa Medicaid Enterprise (IME)). While the interview script was structured the same for all interviewees (See Appendix B), covering six areas, some stakeholders provided disproportionate amounts of information by topics area their organization was involved in (e.g., MCOs described nuances of role in administering HBI program).

Figure 1. Coded Interview References by Type of Organization Represented
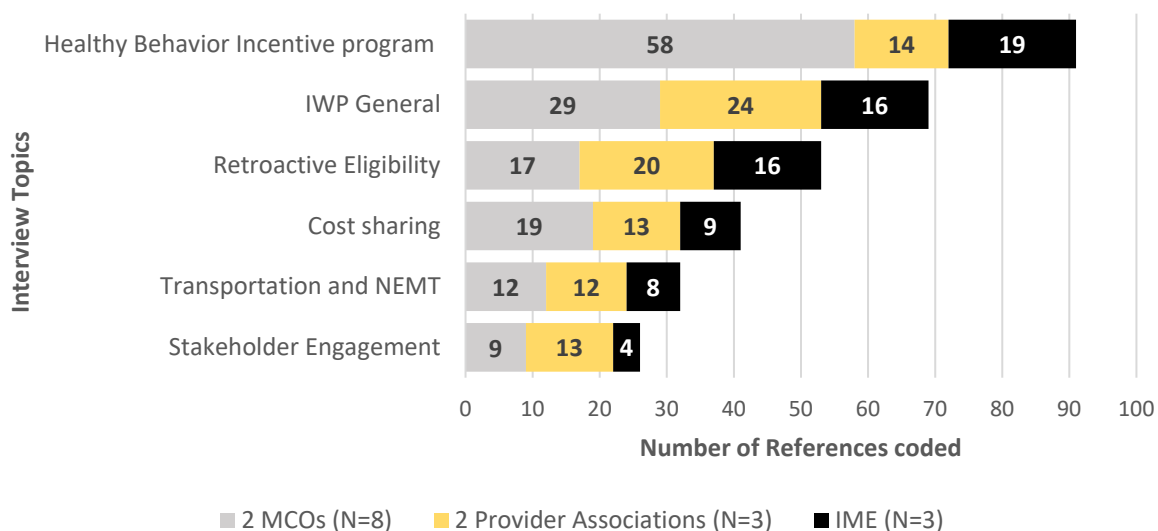
Overall Iowa Health and Wellness Plan

Successes and Achievements

Stakeholders acknowledged strengths and successes of the Iowa Health and Wellness Plan, which included expanded access to healthcare coverage, more reimbursed care provision, improved health outcomes, and opportunities to match formerly excluded populations with appropriate coverage. Full comments from interviewed stakeholders are outlined below:

- **Improved continuity and expanded access to healthcare coverage for more of the state's population**

   "I think it's running fairly well. I can't think of anything off the top of my head that really needs changed. It seems to benefit a lot of people, like I said. And covers that gap and it's very good coverage. The benefits work out very well for the people involved." – Iowa Medicaid representative

   "I think it really has meaningfully increased access to care." – MCO representative

"It's [IHAWP] improved our ability to serve larger portions of our communities." – Provider association representative

"It [IHAWP] just expanded the number of people that weren't able to get care. And I think when we see families being able to have both the adults and the kids seen, I think sometimes the continuity stays better for the families." – Provider association representative

- **Increased capacity of providers to receive reimbursement for more patients and shift resources from providing care for uninsured**

"It's [IHAWP] improved how we are able to leverage and use our federal funds to increase the population we serve, or to expand the services that we offer our current population." – Provider association representative

"Just having the IHAWP program on top of traditional Medicaid was a big win for our provider type. It went from us having to cover a number of folks, so we can't federally turn anybody away for their inability to pay…So, it created space and room for us to grow to serve more people, to get paid for a population we were already seeing, who was uninsured or underinsured... So, I think, for us, we truly do think that the expansion program was a big win for the state and for our population." – Provider association representative

- **Improved health outcomes for the IHAWP population**

"It's improved health outcomes in our patient population." – Provider association representative

- **Provided opportunities to identify members who meet eligibility requirements for the basic IHAWP and assess needs for potential inclusion in more expansive benefits via qualification for medically exempt status**

"The only thing [success] I can think of is where we work to identify members that would meet the exempt status and work with them and work with the state to get them moved to the medically exempt rather than the general wellness plan…So part of our role when we're engaging with my members in the health and wellness plan is for those that are not in a medically exempt package, but have the need, we support the member, making sure they're educated on who they need to speak to, what the responsibilities are for their provider, so they can get that application submitted and ultimately transition over to the medically exempt portion of that benefit plan. So very, very intentional efforts on our part to support that with the members since program inception." – MCO representative

Areas for Improvement

Stakeholders acknowledged areas of the Iowa Health and Wellness Plan, which could be improved, including streamlining enrollment types within IHAWP, enhanced state oversight, stabilization of MCO providers (prevent disruptions caused by MCOs entering and leaving contracts with Iowa Medicaid), and increasing workforce supports, addressing unmet needs in rural care access, and leveraging technology to incorporate innovative approaches like telehealth and smart homes. Full reports from stakeholders are outlined below:

- **Need to streamline categorical eligibility member management within IHAWP and facilitate transition between *medically exempt* and *general population* statuses through automated systems**

"Today it's advocacy work, where we're advocating on the member's behalf, making sure they're educated when they do have one of those conditions that would qualify them for the full medically exempt full benefit package under the health and wellness [plan]. What we have seen in other states is a bit more of a methodical approach that is actually data driven, where the transitions would actually happen automatically and remove some of the steps that have to occur today for a member to do that, which includes both the member engaging with the Medicaid agency, but also the provider has to be engaged and provide information as well. Whereas what we have seen in some of our sister states is a much more streamlined process that is essentially data driven and the transition over would happen automatically. So certainly, something we have advocated for, and we continue to advocate for on behalf of the members…Basically they [other states] have a methodology driven that isolates and identifies the members that have these conditions based on their claims utilization data. And they would automatically, or systematically, get them transitioned over to the fuller benefit plan. So, it is a process efficiency that takes a lot of the burden away from the member, the burden away from the provider. So today it's more of an application and verification process, whereas we see it much more streamlined in some of our other states." – MCO representative

"It gets a little bit complicated in terms of adjudicating benefits. The benefit package is different than with categorical Medicaid, and even if you become medically exempt, the benefit package is different in the space of utilization management and service authorization. That can create a little bit of confusion. Usually, we're able to muddle through and sort things out, but the variability in the various benefits, categorical Medicaid, the Iowa Health and Wellness Plan, and the Iowa Health and Wellness Plan medically exempt creates just enough difference that you got to be very attentive to that... It also creates a little bit of operational complexity because the eligibility files have to be updated, and eligibility categorization, it has to be accurate and to date and timely." – MCO representative

"The one thing that's challenging from my worldview is it's very difficult for people who are in the Iowa Health and Wellness Plan who become seriously functionally disabled and are in limbo between being medically exempt, being categorically Medicaid, and an Iowa Health and Wellness Plan. There is a difficult transition for a few people who probably need more than a standard commercial plan that I think Iowa Health and Wellness Plan was modeled after, and they fall between the cracks…I think that would be the one thing is that there are people in the Health and Wellness Plan who abruptly transitioned to a need that isn't quite captured by the benefit package." – MCO representative

Member Population

Stakeholders shared perceptions of the IHAWP population, noting that most members are employed with demanding schedules and obligations, and limited resources. Some stakeholders also shared that because of prior exclusion from Medicaid coverage eligibility (pre-expansion), IHAWP members have unaddressed healthcare needs, and are less familiar with navigating appropriate use of healthcare types and understanding coverage. Examples of statements about the IHAWP member population follow:

"So as childless adults, they are, they've got some income they're working in most cases. So that makes it difficult to get to a primary care doc during the hours of the day that those places are open and pushes them over to urgent care slash ED. And so, they're the classic group that would put off care and come in when something has become acute. And so, in some cases, it actually is an emergency, but the challenge for Medicaid is it's something that didn't have to be an emergency. And that's the area for the upstream intervention that we spend a lot of time thinking about." – MCO representative

"I wouldn't say they're accessing the ER for primary care. That's a judgment call we're making without details. And so, I think that a couple observations about this specific benefit population, the health and wellness plan. Traditionally, when we see members hit this, they have pent up demands. They have pent up healthcare needs. And so historically the emergency room may have been their traditional method of accessing care. So, you've got, right up front, you've got that education component, making sure they understand the broader resources, making sure they have a primary care physician that they're engaged with, making sure they understand about urgent care opportunities, nurse help lines, all the resources that are available to them. So, you always, with any new member coming in that's never been on Medicaid before you have that educational intervention piece to potentially break some of the traditional habits, if you will." – MCO representative

"Fully employed, worked in multiple jobs, multiple minimum wage jobs, still living in poverty. I think that people would be very surprised, just looking around their neighborhood even, at who might be benefiting from the IHAWP program." – Provider association representative

"One of the holes that you saw with medical coverage or insurance coverage in the past, you had the working poor weren't poor enough to be on Medicaid but didn't have insurance through their employer or whatnot. It hasn't completely solved that, but it's gone a long way to try to help the working poor." – MCO representative

"This group obviously has copays and things that the other populations don't have, and they don't have some of the transportation benefits and things, so there's a little more cost. I would say it's... Probably for most people, I don't think they would see it as a hardship from the standpoint of the thing. I'd say they would see it as a very good value, based on what healthcare costs otherwise." – MCO representative

"[IHAWP population includes people] who, quite frankly, weren't going to the doctor, dentist, therapist, whatever because of cost issues. So, they were having more chronic conditions, they were using the emergency room and urgent care more unnecessarily than they ought to have been and weren't keeping up on preventative care across the board." – Provider association representative

Areas of Emphasis

This report covers various 1115 Waiver Policies, which are areas identified as important from Iowa Medicaid and Centers for Medicare and Medicaid Services (CMS) for understanding the impact of the aspects of the Iowa Health and Wellness Plan (IHAWP) program.

NEMT and Transportation

Results from Key Stakeholder Interviews

Benefit eligibility

Interview respondents discussed the waived NEMT benefit for the IHAWP members, including managing care, assessing member needs, and determining plan fit.

An MCO representative described the disparity in transportation benefits as a notable difference between Iowa's Medicaid plans, saying, *"One of the biggest distinctions and one of the biggest challenges with membership that is in the non-medically exempt categorization is that they don't have the transportation benefit, and it's not covered for them."*

Caseworkers were reported to find the lack of NEMT for IHAWP members to be confusing for members and attempt to assist when possible. An MCO representative described how the identification of a transportation barrier can trigger a more holistic needs assessment, sometimes resulting in members qualifying for more comprehensive benefits by enrolling in medically exempt status, which includes the NEMT benefit, saying,

> *"If a member really is needing care and transportation's the barrier, oftentimes I think we see that there are other pieces missing too. And so, getting them on that medically exempt status really does help them. And so, if we can see that they have other qualifying types of factors, we would really help them to get that benefit added so that we can try and round out how they're getting their care."*

Iowa Medicaid representatives reported that they were not aware of any Iowa Medicaid-led strategies to support the transportation needs of IHAWP members as such support is delegated to MCOs through their care coordination responsibilities.

Alternatives to NEMT and supplemental efforts

Interviewees discussed transportation options for IHAWP members without the NEMT benefit, suggesting utilizing public transportation, social supports (friends and family), and community resources, such as churches.

One MCO representative reported education efforts to support members in leveraging informal transportation options, saying, *"From a day-to-day perspective, for those that are in the non-medically exempt, that don't have the non-emergent medical transportation, education about publicly available resources, encouragement for how to solicit rides from family members"* and *"Our case managers are just really great at helping identify those church resources or family members."*

Representatives from provider associations described the transportation hardship experienced by members and issues with reliability of informal support and lengthy time commitments for members using a public transportation system with limited frequency (exacerbated by pandemic), saying, *"Getting to the appointment, at times, can be difficult particularly. We've seen with pandemics, sometimes bus lines not operating for as long as they used to or having different hours. Folks knowing it takes two to three hours*

roundtrip to get to the appointment and get back, and that's a struggle when they can't necessarily take that much time off work when the appointment is like half an hour of that."

Of informal supports, another provider association representative exemplified the disruption a healthcare appointment can cause IHAWP members without reliable transportation, *"We ran into some problems with the transportation just not showing up. And then not only is that person not able to get back home or to pick up their kids from school or to get back to work."*

A representative from a provider association listed efforts led by providers and clinics to mitigate transportation barriers for members, including applying for federal grants, community foundations, and private grants to finance initiatives, assuming additional liability, and absorbing associated costs.

> *"We've tried to backfill some of that by providing gas cards, by providing fares for taxis. We have a couple of health centers that have established mobile units, so they can go see the patients where they're at a little more easily, than having to try to get the patients to them. We have [clinic] get additional liability coverage, and now does offer some limited transportation options of their own for patients as well, at their own cost. There's a multitude of different things we've tried and are continuing to try. Some things are more successful than others."*

Despite providing in-kind assistance such as gas cards, barriers to reliable transportation endure, as one provider association representative, illustrated, saying, *"With the gas cards, I think the issue is, just because they had money from us to buy gas doesn't mean that they had a car that worked."*

A provider association representative speculated on potential solutions, both through enhancing public transportation options and exploring ride share models, saying, *"We hear about DART [Des Moines Area Regional Transit Authority] is moving to smaller buses, trying to be more nimble. I think that there's an opportunity for the system to move to more of an Uber type model, where it's call on demand."*

Workforce shortage impact on NEMT services

While IHAWP members are not eligible for NEMT services, interview respondents described the impact of the workforce shortage on availability and reliability of NEMT services, with an Iowa Medicaid representative attributing a lack of drivers to increased incidents within the program. One MCO representative described systemic transportation barriers associated with the workforce shortage, noting barriers to healthcare access even for members with an NEMT benefit, saying, *"We're working against a workforce challenge as there are in so many industries in Iowa, and this transportation thing has hit particularly hard by it. Whether you talk to a transportation vendor or a provider. And that doesn't necessarily impact the policy making in Medicaid. I'm not sure if you added in a transportation benefit that would impact the workforce challenge at all, but it is a sort of bedrock reality for people. And it is probably the number one concern is just pure access due to the availability of the service."*

A provider association representative commented on the reliability and appropriateness of NEMT services generally (not related to workforce shortage), saying, *"Many times, though, people don't come when they say they're coming. They don't pick them back up from the doctors. Medicaid members are having to wait for literally hours. If the individual has a significant disability, they may need assistance getting to and from the vehicle... It's a problem."*

The same representative elaborated on ideas for resolutions and improving the quality of NEMT to better serve Medicaid members, saying, *"Ongoing conversations with Access to Care, and with both MCOs and Iowa Medicaid about that and urging them to provide more training with regard to their drivers about the nature of the population that they're picking up, being a bit more lenient, the importance of being on time, having*

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better communication. Our push has really been with state leadership and the MCO leadership to get Access to Care to be more flexible and more effective in their delivery."

Key stakeholders shared perceptions about the member experience regarding transportation and healthcare, including competing priorities, awareness of waived benefit, and options for recourse.

An estimated 74% of IHAWP members are employed at least part time, and report barriers in scheduling appointments around work (27% of IHAWP members reported foregoing routine care because of not being able to take time off work).(1) About 10% of IHAWP member directly cite transportation to the doctor's office as a challenge. The majority of IHAWP members engaged in employment still meet the income threshold to qualify for benefits, suggesting they occupy low-wage or limited-benefit jobs (e.g., paid time off for healthcare), so time for appointments becomes scarce, and jeopardizes income stability, especially if transportation options are lacking efficiency (e.g., waiting for a ride, relying on bus schedule, walking). A representative from a provider association said, *"[Transportation need] Huge. Particularly for our patient population…They have transportation constraints, they have time constraints, their work schedules may not mesh with it… I think that puts some burdens on our providers as well."*

A representative from an MCO commented on the level of awareness of IHAWP in benefits available to them, saying *"Every once in a while, we will see it where maybe even it's that a member doesn't realize they don't have the transportation benefit. They think they do."* Communication with IHAWP members about transportation benefits is portrayed alongside more comprehensive coverage plans which do include transportation. Figure 2 shows the table of contents for each MCO's member handbook, both of which list "Transportation benefits" under "Covered Benefits and Services." Within each of the 90- and 133-page member handbooks, groups which are eligible for transportation benefits are accurately delineated, but it is conceivable that IHAWP members might infer that their coverage includes a transportation benefit.

Figure 2. Iowa MCO Member Handbooks, Excerpts from Table of Contents (Amerigroup left, Iowa Total Care right)

COVERED BENEFITS AND SERVICES
Medical benefits
Vision benefits
Transportation benefits
Dental benefits

Covered Benefits and Services
Medical Benefits
Vision Services
Transportation Benefits
Dental Benefits

Additional marketing material distributed by MCOs may contribute to member misinterpretations about transportation benefits. For example, Figure 3 shows a brochure advertising transportation service to Iowa Total Care members, with an asterisk noting restrictions (e.g., not applicable to IHAWP members).

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Figure 3. Excerpt from Iowa Total Care promotional brochure advertising transportation services
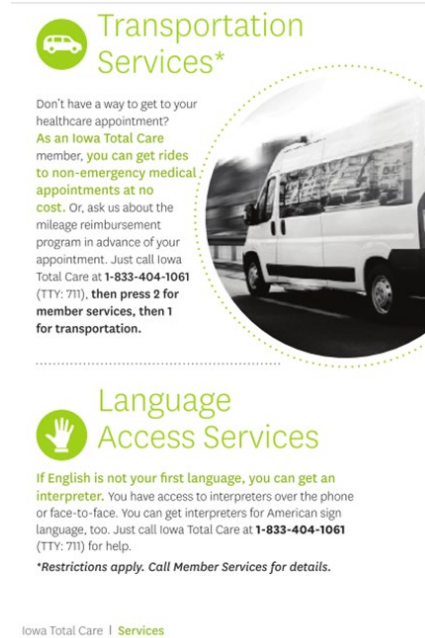
A representative from Iowa Medicaid reported that members do have options to express dissatisfaction or unmet need regarding transportation, either through a formal grievance process or direct emails to Iowa Medicaid leadership, saying, *"The member always has information on how to file a grievance, if they need to file a grievance. I know that we've had members email me directly, email Liz, Medicaid Director directly with any concerns that they have with that transportation piece."*

Prevalence of Transportation Need

Interviewees shared various perceptions of the level of transportation need amongst IHAWP members. Representatives from both MCOs and Iowa Medicaid reported that unmet transportation needs were not an urgent issue for IHAWP members, saying health-related transportation, *"just hasn't been as front and center lately"* and *"it's not a burning daily issue that we hear about"* and *"it's not a top response that we get as being a problem."* One factor potentially contributing to the assessment that *"the degree of intensity and visibility of this challenge [transportation] today, it's not as prevalent,"* could be the decrease of in-person healthcare utilization during the pandemic and uptake in utilization of telehealth options, which have been shown to mitigate transportation as a barrier in accessing care, particularly for rural residents.(2) Representatives from provider associations and Iowa Medicaid noted that health-related transportation need was a more prevalent barrier to care in rural areas.

One issue in capturing the prevalence of unmet transportation need is the ability to systematically elicit and respond to self-reported SDH barriers. Members experiencing transportation hardship encounter additional adverse circumstances, which can complicate identifying transportation as the sole barrier to adhering to healthcare, as illustrated by a provider association representative comment, *"They have transportation constraints, they have time constraints, their work schedules may not mesh with it."* A representative from an MCO elaborated on the challenge of tracking transportation hardship, saying, *"You can't draw conclusion from utilization patterns or medication adherence that you couldn't presume that it was because of transportation barrier. Typically, the best way we would know is if a member were to communicate that to us, or a provider, even in some circumstances, may alert us to the fact that somebody has a, a transportation challenge."*

In contrast to perceptions of a low prevalence of unmet transportation need voiced by some key stakeholders, an MCO representative described transportation as *"It's the number one [barrier]"* and linked the lack of transportation benefit to *"almost seven years of member frustration."* In addition, a provider association representative described transportation for IHAWP members as 'huge' and 'always a concern', saying, *"For a lot of the patients, some of the things that they need, they have to go somewhere else; they have to go to University of Iowa or somewhere. And so, finding help and finding reliable transportation to get them to those appointments is always a concern. Whenever you're out listening to people talk about barriers to care, it always seems to be able to get the patients connected with some kind of reliable transportation."*

Additionally, an MCO representative shared perspectives on the cumulative impacts of transportation hardship on health, saying,

> *"You're stuck in a food desert. If you can't get to the hospital, you could be home languishing ill. If you can't get to primary care, you can't get your preventive health. Even if you take it outside the context of healthcare services, you can't get to the library, you can't get your books, and read, and all that stuff. Health and Wellness Plan, non-emergent medical transportation, I think it's a really valuable component to the other parts of the Iowa Medicaid enterprise benefit, but I don't have any insight into whether or not it's worked out as planned."*

Spillover Effects of Unmet Transportation Need

Unmet transportation need has impacts beyond the individual patient's access to care, as illustrated in this remark by a provider association representative, *"We try to leave spots open and be generous with people, trying to fit them into the schedule when they can get there, and leave some same days open if somebody, transportation doesn't work out one day, but they can get there the next day for sure. But there's cases where care just doesn't happen too. We try to prevent that, but sometimes you can't, particularly if it's a more involved medical procedure or... Same thing, dental too, if you're there and slotted to do four cavities, it takes time. And if they get there late, maybe they're only getting one cavity done."*

In prior sections of this key stakeholder interview report, several spillover effects (e.g., impacts not directly intended by the policy) related to the NEMT waiver for the IHAWP members emerge from the content, outlined below:

- Members
  - Lack of direct, reliable, timely transportation to healthcare appointments diverts time and resources from work, caring for dependents
  - Members relying on informal or inadequate public transportation risk missing appointments, shortened appointments, or foregoing care completely
  - Effort and time required to understand eligible benefits specific to their plan, within general communication about all types of Medicaid plans
- Social networks of members
  - Members utilizing personal networks or community resources like churches to solicit transportation attend appointments can burden family, friends, and volunteers
- Providers
  - Staff time spent securing grant funding to meet unmet transportation needs

- o Assuming additional liability to provide transportation
    - o Absorbing associated costs with members missing appointments due to transportation barriers
    - o Investing in alternative forms of transportation and mobile outreach to provide care
- Caseworkers
    - o MCO-based caseworkers' effort in assisting members in navigation of plan eligibility, limitations, and responsible for providing education about transportation options
- Medicaid population and spending
    - o IHAWP members with unmet transportation needs may be determined eligible to enroll in more comprehensive benefits associated with medically exempt status, affecting cost per member

Healthy Behaviors

Results from Key Stakeholder Interviews

Goals

Across interviewees, there was consensus about the goals of Iowa's Healthy Behaviors Program, which included:

- Engaging members in their health care
- Promoting utilization of preventive (versus reactive) services
- Connecting members to a primary care provider and
- Encouraging members' awareness of their own health status
- To Improve health outcomes

In addition, a representative from Iowa Medicaid included reducing emergency room visits as a goal and an MCO representative included the goal of educating members on appropriate health services use and increasing wellness behaviors (e.g., exercise and weight loss). Representative comments include:

"I think the overall goal is to promote the health and wellness of the member, ultimately. Putting the consumer in the place where they are in control of their own health care."

"To get a member in for an annual screening, both either dental or physical and, or assess their overall health and wellbeing needs through the screener and get them in annually so that the MCOs can provide the services necessary."

"I think the goal...is to have people go to their doctor at least once a year, try to identify any issues that come up and have more preventive care versus acute care."

"To get people into the doctor, and make sure that they're being cared for. It's in their best interest health wise."

"Yeah, just to be aware of their own health status and to encourage preventative and routine care."

Effectiveness towards goals

Interview respondents did not have substantive responses about whether HBI components and related efforts were directly associated with improvements in member health (through the use of preventive care or completion of a health risk assessment), but respondents indicated that the reasoning behind the incentivized requirements were valid. Regarding participation rates, one MCO representative said, *"I don't know the numbers about who's taking advantage of it."* Another MCO representative noted the alignment between the state's HBI program and managed care approaches, saying, *"I think it's perfectly aligned with what we want to help people do with their health benefits."* Another MCO representative elaborated, saying,

> *"What I've really been impressed with, at least in that healthy behaviors component, is how aligned that strategy is with what we're trying to do in managed care, strengthening health risk assessments, encouraging people to use preventive services, the underpinnings of the Iowa Health and Wellness Plan design, at least in terms of health promotion. I think our care management teams and just our overall philosophy of benefit administration is very much in line with that. I think one of the things I think has happened, that's gone relatively well, has been alignment with the Iowa Health and Wellness Plan design structure, the design of the strategy behind managed care."*

One MCO representative said of the HBI requirements, *"I think it's a pretty standard strategy in health plans. I think it's a great idea myself, and I wish more people took advantage of it."*

One provider association representative shared perceptions that members and providers are aware of the HBI components and members are able to complete these two things without too much of a burden.

Health Risk Assessments

Health Risk Assessments (HRAs) are administered by MCOs for the entire Medicaid population, not only IHAWP members. Health Risk Assessments (HRAs) meeting the criteria to fulfill HBI requirements are administered by the state's MCOs, both of which provide a separate incentive (in addition to the state's premium waiver incentive) for completing a health risk assessment required by the state. One MCO representative stated, *"the purpose of this assessment is to gather additional Social Determinant of Health (SDH) information used for data collection and risk stratification."*

Representatives from both MCOs noted the contractual obligations of administering Health Risk Assessments to IHAWP members, saying *"the health risk assessments are a contractual requirement we have in this program. And so, it's not a nice to do, or if we want to do, we have to solicit and collect health risk assessments"* and *"we are, by contract, obligated to do that health risk assessment from the state."*

One provider association representative stated they had no awareness of HRAs associated with the HBI program.

HRA Content and Development

Interview respondents reported collaborative efforts in the form of workgroups and to promote alignment of HRA content across MCOs. One MCO described the process to align HRA content, saying, *"while each of the MCOs has developed a proprietary health risk assessment that was launched into the market initially, a lot of work has been done around bringing those into harmony with what Iowa Medicaid has developed and placed on the dashboard that was launched pursuant to a work group that's been meeting for about the last two and a half years or so. So, they did pull together 13 questions that are now asked by both of the MCOs and by Iowa Medicaid and fee for service, and at least on those questions related to social determinants and some other health behaviors, there is some alignment across the board."*

The report from this MCO representative about the inclusion of Iowa Medicaid fee for service members in the HRA population was in contrast to the Iowa Medicaid representative report, who stated, *"I believe that those on FFS are members that are part of the exception to the health risk assessment part."*

MCO representatives praised the state's efforts to establish standard Social Determinant of Health items across HRAs, saying, *"I think what we did to agree on a 13 question, unified social determinants of health assessment was a really big victory in this space. And that is actually very innovative in terms of how states operate, and something's being shared out across the country right now"* and *"many of those questions overlap with the health risk assessment from the state. My point is the data are valuable and looking at them in aggregate, I think has created new opportunities for our plan, our members, and things for the state to be doing that are different and I would even argue innovative."*

Representatives from both MCOs shared perceptions of general alignment across HRAs administered within each of their managed care strategies, saying, *"as a practical matter, the MCOs that are operating in the Iowa market right now have extremely similar health risk assessment questionnaires or surveys that go out to members and store and retain and communicate their data in very similar way,"* and, *"our care management program has a health risk assessment. Many of those questions overlap with the health risk assessment from the state."* An MCO representative elaborated on the rationale behind the HRAs, saying, *"that philosophy of using the data to try to create new ways for people to be healthier is perfectly in alignment with what we're trying to do, and helpful to what we're trying to do."* A representative from Iowa Medicaid confirmed state involvement in content development for both MCO HRAs, saying, *"the scripting had to be approved by the State as well as the assessment."*

A representative from Iowa Medicaid concurred with the alignment of about 13 items across HRAs, saying, *"so the assessment that we originally do upon first contact it's 13 questions, I believe, 11 or 13 questions. So, it's just a really quick overview of some different areas. And then that triggers a score, and "as far as aligning with what Iowa Medicaid uses, I'm pretty sure that, from what I remember, [MCO] HRA assessment was aligned to be comparable to that of Iowa Medicaid."*

There was some uncertainty amongst stakeholders about whether the state maintained its own HRA (separate from the HRAs deployed by MCOs). A representative from Iowa Medicaid said, *"I'm not sure. It sounds like that [MCO] Health Risk Assessment is probably the same one that is used for Iowa Medicaid. I've never seen it though. So, I don't know. I've seen the one that's used for us or for the Healthy Behaviors for the Iowa Health and Wellness Plan. They're very similar."*

One MCO representative suggested that the incorporation of standardized measures added length to member HRAs, saying *"we like it, but it probably has created a tool that's a little bigger than it necessarily needs to be."*

Finally, representatives from both MCOs mentioned additional care / case management services available to members on an opt-in basis which includes additional health risk assessments and educational outreach.

The content of each HRA used by MCOs were cross-referenced for content overlap, results are outlined in Appendix A.

Data Use

Key stakeholders shared examples of how HRA data was used for individual case management, population-level information, provider education, and reporting compliance.

Data uses

- **Understand and respond to member needs at a population level**

  o *"We are actually just starting now that we've got a solid amount of data behind us from the screeners and capturing that from the SDH stuff, we've started to do some analysis and we've started working that into, we've got a lot of population health projects and health equity projects going on."* – MCO representative

  o *"We've used it to not only contemplate but actually to initiate some added value benefits for our members around access and reducing barriers."* – MCO representative

  o *"Now that we all uniformly collect social drivers of health data off of that as well, that can also be used to inform opportunities in more community-based interventions outside of the traditional health care space."* – MCO representative

- **Inform providers of population level issues and develop programming**

  o *"We've actually been using it to try to inform our network providers on ways that they might be able to think outside the box on social determinants of health and intervening on social determinants of health."* – MCO representative

  o *"We use the Social Determinant of Health data received from the HRA in addition to other available data, to ensure the Value-Added Benefit offerings we provide to members are adequately addressing and supporting member identified needs. We also incorporate the data received from the HRA into development of programming such as our Population Health and Health Equity Projects."* – MCO representative

- **Inform individual member case management**

  o *"It's more traditional and making sure we understand what the member's needs are. It's a critical trigger point for us to say, "Oh, okay, really, we think you would benefit from some case management support here." It really informs both a clinical approach in many circumstances."* – MCO representative

  o *"Do a screening type tool to see what their score was to see if they could benefit from case management services. And that was a component that helped assist with that high utilization. If we enrolled you in case management, we could be taking care of these concerns ahead of time keeping you at out of the ER, getting you appointments as needed. And then building in care plans to address all those different areas."* – Iowa Medicaid representative

  o *"We put a lot of energy into that health risk assessment and then using the data from that health risk assessment to help people be healthy. It's actually so central to what we do. I wouldn't even call it an initiative. It is what we do, so it's core to our strategy."* – MCO representative

  o *"We use the data from the HRA to further risk stratify our members for outreach and engagement into care management for care gap closures and care support/transitions. If a member answers 'no' to not having a PCP or having a wellness exam in the past year, we have a team to outreach and help coordinate PCP/office visit scheduling."* – MCO representative

  o *"I mean, there's so much valuable information that can be gleaned with that. And we do a lot of connection with our case management based on their responses."* – MCO representative

- o *"On an individual level, if a member identifies on the HRA as having certain health conditions or Social Determinant of Health needs and indicates they would like assistance, case management reaches out to that member to both support the member and connect the member with resources to improve the member's overall health and wellbeing."* – MCO representative

- **Quarterly waiver federal compliance reporting**

  One MCO representative shared details about HRA completion rates, noting that members would be excluded from the calculation after three contacts were sent regarding the member's obligation to complete the assessment to waive monthly premiums, saying, *"once we've made three attempts for that purpose [ensuring members are aware of HBI process], then we can remove them from that denominator on that report. It doesn't mean we don't make other attempts so there aren't other ways we do, but…we use mailings to satisfy that requirement."* Another MCO representative agreed, saying, *"there's three times that I'm aware of"* in regard to contacting members to ensure awareness of the two HBI requirements and additional incentives.

  A representative from Iowa Medicaid reported a hiatus in quarterly reporting during the public health emergency, saying *"All the data that's collected goes to CMS. We have an annual report with then, and we have a quarterly report for each quarter that goes to them that has that data in it. But again, it's been zeros for the PHE."*

  - o *"I believe the MCO is responsible for identifying refusal and unsuccessful assessments. The universal data pull is for audit purpose to ensure compliance. I am not aware of how copays are determined. As far as the HRA assessments, the MCO reports on HRA completion. Every member is required to have one so the state can request that the MCOs pull a universe and do a HRA completion evaluation. I am unsure how often this occurs but believe it was quarterly."* – Iowa Medicaid representative

- **Establish a publicly available statewide data resource (under development)**

  - o *"There's a work group has been in place that involves elements of the Department of Human Services, Iowa Department of Public Health, and the MCOs to coordinate and build what is ultimately a public dashboard that backend data is available to us as well. We're involved in socializing that data around to provider associations, boards, and commissions, any healthcare stakeholder in Iowa to make sure they can access that data set. I don't know how robust the utilization of that information is at the moment."* – MCO representative

Data Sharing

Key stakeholders shared information about the processes and expectations related to exporting and sharing data across MCOs and Iowa Medicaid. Stakeholders representing Iowa Medicaid and MCOs reported routine (both monthly and quarterly increments reported) data transfer of member HRA completion rates.

The state's MCOs are responsible for sharing HRA completion rate data, as MCO representatives explained, *"it's part of our quarterly reporting. We have to report out on attempts, made to members to complete the screener. And so, we report that out to the state"* and *"we report that data over on a monthly basis to Iowa Medicaid on members that have completed their health risk assessment."*

A representative from Iowa Medicaid concurred with MCO representative reports of sharing member HRA completion rates, saying, *"as far as sharing with the state, the MCOs do have to pull universes, and send to the state to make sure that we are compliant with getting those completed."*

An MCO representative clarified that routine data sharing with the state for waiver compliance purposes was limited to population-level outcomes ("that doesn't have the individual responses to the HRA"), but added additional item-level data sharing inclusive of the standardized SDH question in the assessment, saying *"we do report that information on a different file on a monthly basis to Iowa Medicaid and it's got member level ID and responses now, granted, I will say this is for SDH purposes. So, it doesn't have every single response to every question, but it's a subset of questions that Iowa Medicaid has identified as being relevant to the SDH realm that we report."*

An MCO representative described the data sharing process of the MCO-specific HRA results as transparent, saying, *"while we may be soliciting the health risk assessment data, that is program information, it's not just ours, it's available to the state. We share a lot of that information with the state, if not all of it."*

One MCO representative commented on the tracking of member compliance with the state's HBI requirements, noting occasional instances of under-reporting credit for completing an MCO HRA within the state's premium enforcement system, but included that MCOs were involved in resolving erroneous premium charges, saying *"they've said for some reason I got charged a premium and they'll call us. And we said, 'Yeah. We can see that you completed these things.' So, I mean, generally, or my understanding has been that if the member talks with Iowa Medicaid and says they completed this, that Iowa Medicaid generally waives that requirement, but I know that our case managers have helped facilitate some of that, I believe."*

A representative from a provider association was not aware of how data was shared, saying, *"I hope the MCOs are sharing that data with the state, and the state's sharing it with the MCOs, but I don't know."*

Coordination across stakeholders

Interviewees discussed collaborative efforts across statewide stakeholders related to HBI, primarily focused on health risk assessment development and implementation.

There was some uncertainty amongst stakeholders about whether completion of the MCO-specific HRAs met the qualification for the state's HBI HRA requirement. For example, one MCO representative said, *"You are challenging me in terms of my understanding of what we do as a health risk assessment versus what constitutes a health risk assessment for the benefit. I guess I have always assumed that the questions that the state has mandated that we ask are part of that plan benefit, but I don't know that."* Another MCO representative stated they had "no insight" as to whether HBI HRA requirement could be met through MCO HRA completion. Another MCO representative stated, *"I don't know confidently that I can say they're one and the same [MCO HRA meeting state HBI requirement]."*

Along with uncertainty, some stakeholders reported perceptions that the MCO HRAs were separate from a state administered HRA which fulfilled the Healthy Behavior HRA requirement. One MCO representative said, *"we have our own health risk, social determinants of health tool, but we combine it with the health risk assessment from the state and the social determinant information that they get from that."* A provider association representative said, *"I think they are separate. I believe that both of them consider them value add. I don't think that the state requires that. It's separate from the healthy behaviors program. It's meant to be more value add."* One MCO representative stated, *"I think the overall topic here is, are there multiple assessments that are out there in the world? And the answer is yes. And the dream of a unified assessment is one we share with Iowa Medicaid and everyone else. And it's not for lack of effort that that has not come into existence."* In

addition, a provider association representative reported, *"I've heard some providers, not necessarily ours, some providers complaining that they're duplicative [state HBI program and MCO value-added benefits program], I've heard some patients commenting that they're duplicative."*

Other stakeholders asserted that MCO-specific meet the state's HRA requirement within the HBI program, with one MCO representative saying, *"the HRA that we complete, with our members, has been approved by the Iowa Medicaid."*

MCO representatives described the relationship between their roles administering the HRA to meet state requirement and MCO-specific incentives, noting that MCO value-added benefits are completely independent from the state's health risk assessment incentives, saying, *"A lot of our [value-added benefits] are tied to our enterprise quality team they push down. So, there's not even a real strong tie solely to Iowa [value-added benefits] is not dependent nor directly related to the health risk assessment. One may inform the other, but they are independent. I mean, healthy rewards is our value-based program where we provide incentives and what we call value added benefits."* Another MCO representative responded similarly, saying *"[Value-added benefits program] not directly correlated to either of those [state HBI requirements or MCO role in administering HRAs], although data collected from health risk assessments helps inform us to target which of our rewards programs a member may benefit from. But it is wholly separate from both of those processes, quite frankly."*

Figure 4. Summation of Healthy Behaviors Incentive Program Process as Described by Key Stakeholders

State HBI program incentivises completion of HRA

- Iowa Medicaid informs members directly about HBI actvities in order to waive montly premium
- HRA content is specfic to MCO, but includes standardzed statewide items (see Appendix A)

MCOs administer HRAs to members

- MCOs are responsible for contacting members three times to promote awareness of Iowa's HBI protocol
- Communication about state HBI HRA requirements is included in member handbooks
- Encouragement to complete HRA also commuciated as a separate incentivized activity by MCOs

IHAWP members complete HRA of enrolled MCO

- Members receive value-added incentive from MCO*
- MCO reports member-level HRA completion to Iowa Medicaid, waiving monthly premiums for compliant members

*Each MCOs value-added benefits (e.g., sending members gift cards) are completely independent from state HBI administration

In a collaborative initiative separate from administering HRAs, one MCO representative described coordinated efforts across state stakeholders in pursuit of implementing value-based purchasing payment models using HRA data, saying, *"that was the beginning of 2021. We were part of monthly meetings with Iowa Medicaid and [MCO] and trying to work out, we had to pay for performance measure from Iowa Medicaid tied to those SDH questions. And so, there were lots of meetings to figure out, make sure we were reporting the data consistently between the MCOs."*

Key stakeholders reported added efforts undertaken to successfully implement and support the state's Healthy Behavior Incentive program, which include MCO-specific value-added benefit programs (includes incentives for HRA and annual wellness exam completion), provider education efforts, creative member communication, informing outreach to establish primary care connections with claims-based utilization data, and efforts to address Social Determinants of Health needs identified in HRAs.

As shown in Figure 4, value-added benefit programs administered by the state's MCOs are independent initiatives from the state's Healthy Behavior Incentive program. One MCO representative described how their value-added benefit program supplements the state's efforts, by *"trying to encourage and bolster the numbers for completion of health risk assessments. We're leveraging that value added component to encourage the completion of the annual health risk assessment."* Another MCO representative added, *"We also incent an annual wellness and visit for members. So, we're also trying to promote that on our end as well, that's important, that's the first line of defense here to getting member and getting them engaged with their PCP and trying to get them, their needs met."* A representative from Iowa Medicaid confirmed awareness of MCO value-added benefits and promotion amongst members, saying, *"they would also do follow up letters to remind them, these are some of the things that you can do to take advantage of this reward. And what you can do to earn points? What can you do to get extra money loaded onto your card?"*

One MCO reported strategies to bolster member participation and encourage provider involvement in completion of healthy behaviors, saying, *"We've got marketing materials that we promote the screener with and wellness exams. We do education with our providers around the importance of completing this. We've got different reps assigned to the clinics and so they do some education there with it. We do texting campaigns and call campaigns for our members to get them in for their wellness exams."*

An MCO representative described plans for additional efforts to identify (through utilization claims) and connect with members utilizing acute forms of health care (as opposed to preventive) if standard attempts associated with HBI implementation are not successful, saying, *"we plan to start looking at members who have had two or more claims and sending somebody out in person just to connect them with resources and make sure they get connected to the PCP. And many times, these are going to be members too that we've had no luck contacting through other forms."*

Both MCOs maintain efforts to address member Social Determinant of Health (SDH) needs through linking members to Social Determinants of Health -related resource navigation database. An Amerigroup representative reported connecting members with SDH needs to findhealth.org and Iowa Total Care reported connecting members with "unfavorable" responses to HRAs to community resources and services (unspecified).(3)

Key stakeholders described interactions with members related to the administration of the HBI program, including types and frequency of communication and disparate engagement and completion rates across IHAWP subpopulations.

Regarding member options to complete an HRA to fulfill IHAWP expectations, one MCO reported options to complete the HRA over the phone or in the MCO's member portal. The other MCO reported members are able to complete the MCO's HRA on the web, through mail (paper HRA), or over the phone. One MCO elaborated on preferences for maintaining up-to-date data in member HRA

completion, saying, *"we encourage our members to complete it on the web, just because that is the quickest way the information is funneled directly into our system obviously, for them to get a reward and, or make sure that we've captured that data to have their premium waived."*

Stakeholders talked about efforts to inform members about the HBI program, from both Iowa Medicaid and MCOs, which together culminate to a mixed-method communication and reminder campaign, including messaging via:

- Member handbooks

- Mailed letters (occasional neon paper)

- Information posted to state and MCO websites

- Texting (cell phone)

- Phone calls

    o Incoming from case managers

    o Call center availability (outgoing from members)

- Flyers

- Postcards (occasional neon paper)

As this list of communication methods demonstrates, and one MCO representative stated explicitly, *"we actually put a lot of effort into promoting the health risk assessment among our members."* Additional illustrations of member communication generally identify MCOs as leading communication efforts related to HBI, and include the following:

- *"We helped them create actually a letter so for a mailing. And they wanted us to use this mailing, so it's one of three letters. There's one that says you still need to complete your screener. You still need to complete your wellness or you still need to complete both. And so, we email those out 60 days, I believe 60 days prior to the member's annual enrollment date. And so that's just on a rolling basis. So, we're mailing those out monthly to the members that have their annual enrollment date coming up."* – MCO representative

- *"I know they have them on their website. They use texting. Their case managers talk about those with the members. I think it's pretty well known. I know that the MCOs send out materials to members as well."* – Provider group representative

- *"So, I would think that they'll be advertising during that year, sending out flyers and things for them. But I'm not sure what that looks like."* – Iowa Medicaid representative

- *"Well, certainly it's going to be structured inside of our member manuals. Our call center agents are trained with the appropriate information should they receive a question when a member engages there as well."* – MCO representative

- *"They [MCOs] do some outreach on the phone too [in addition to mail]. And then there's also the Internet. So, there are other ways of communication, definitely."* – Iowa Medicaid representative

- *"I believe the broader educational piece or guidance piece would reside within the member handbook, would be my expectation there. I believe the state also sends a cover letter that has information like that when they send their eligibility notification out. So, each member has that information available to them*

at the point of enrollment about the waivable monthly contribution from the member." – MCO
representative

- *"Instead of letters being in envelopes, there was often times, brightly colored postcards, or things that would stick out if there was, we even did neon paper for some things to help it stick out instead of just plain white paper to help kind of draw their attention to it." – Iowa Medicaid representative*

Member communication regarding HBI are perceived by some stakeholders to be effective at raising awareness and providing clear information (evidenced by an absence of member inquiry) with one MCO representative saying, *"we don't have members reaching out to us or engaging us saying, 'I didn't know about this. I was confused about this. What's this for?' That doesn't occur. So, from that perspective, I would say it appears the communication methods are effective and redundant, quite frankly."* Several stakeholders perceived HBI-information campaigns to approach overcommunication (described by some as "ongoing," "nonstop" and "bombarded"). Another MCO representative commented on the saturated nature of communication efforts, which motivated a change in strategy, saying, *"we used to call members as part of that [HBI-related communication] too. And we've stopped that, or actually I stopped that because I think it was causing some abrasion. I just don't think that was a very effective method and people were getting irritated by that. So, we moved to strictly mailers."* Regarding the MCOs contractual obligation to contact members at least three times before removing them from completion reporting denominator, one MCO representative said, *"we get feedback from some members saying they think three is a lot and they're not very happy about it."*

During the federal Public Health Emergency (PHE) (effective March 2020 – current), monthly premiums and disenrollments for members out of compliance with HBI requirements are suspended, but communication about the program presumably persisted, as reported by an Iowa Medicaid representative, saying, *"They still get the information for that [HBI]. Although, I'm not 100% sure. But I think that is still sent out by the MCOs, even though the PHE is going on, it's just not required at this point."* Regarding efforts to re-educate members about HBI protocol following the PHE, an Iowa Medicaid representative was not certain or aware of state-led efforts, but speculated MCOs would lead, saying, *"I know that a lot of the information that goes out comes from the MCOs. But I'm not sure what they're doing with that. Right now, obviously nothing. So, I'm not sure once it kicks back in [after PHE} how that'll work."*

HBI participation disparities

Disparities in participation and completion rates across demographic groups have been consistently documented in the state's HBI program. (4, 5) While MCO representatives described overarching values of health equity and strategies to mitigate health disparities in other health outcomes, no efforts were reported specific to addressing the HBI program disparities.

Representatives from MCOs representative stated, *"we put a lot of energy into trying raise the bar for health risk assessments for groups of people that we see at unique risk, uniquely vulnerable"* and *"I don't know that I can say that for the health risk assessment we've specifically applied any of those targets to this date, but certainly the capability exists for us to do it… Capability exists, but I don't know we've ever employed that specifically for the health risk assessment."*

A representative from Iowa Medicaid responded, *"I do not know. I know that the MCOs have submitted a health equity plan to help how they're going to address making sure that all members are getting that equal outreach, and how they could focus on those health disparities."*

Spillover Effects

In prior sections of the key stakeholder interview findings, several spillover effects (e.g., impacts not directly intended by the policy) related to the HBI program for the IHAWP members emerge from the content, outlined below:

- Members

  - Members with the least time, resources, and employee-sponsored benefits like paid sick leave, may not be able or motivated to prioritize a preventive visit (due to other obligations, like work and caring for dependents).

  - Disparities in members who are subject to monthly premiums and disenrollment exacerbate existing inequities in health care access, in addition to introducing financial stress, and disrupting coverage continuity.

    - *"[HBI is] maybe one of the more complicated pieces. Because it is a financial driven thing where they have to contribute, which is only five to $10. But for some people that is a big deal... I mean, some people may struggle with that. I don't know. But that would be a place maybe of curiosity when the PHE [ends] of how many people are dis-enrolled and re-enrolled."* - Iowa Medicaid representative

  - Dual wellness exam and HRA awareness promotion campaigns from the state and MCOs can be difficult to navigate.

  - Overcommunication and reminders about HBI can overwhelm members, resulting in lower engagement with important information. Member experiences, verification of receipt, and communication preferences cannot be solicited and integrated with one-way communication (e.g., mailers).

    - *"We used to call members as part of that too. And we've stopped that, or actually I stopped that because I think it was causing some abrasion. I just don't think that was a very effective method and people were getting irritated by that. So, we moved to strictly mailers."* – MCO representative

  - Effort, health literacy, reliable and affordable access to a phone or internet,* and time required to complete HRA.

    *One MCO does not have a paper / mail in option for the HRA

- MCOs

  - Added administrative duties

    - MCO-based caseworkers' effort in assisting members in navigation of HBI requirements versus value-added incentives.

    - Developing and executing multi-pronged communication campaigns and reminders, delineating state and MCO efforts to encourage healthy behaviors

    - Caseworker time is spent verifying HRA responses, as reported by an MCO representative, *"if we get things and they're surveys and they're incomplete, we're calling members reaching out to try to clarify that information."*

- Iowa Medicaid Enterprise

  - Funding program administrative efforts to achieve member behaviors which MCOs already incentivize (with little measurable impact on participation or evidence of return on investment).

  - Added administrative duties

    - Issuing refunds to members erroneously charged premiums

    - Coordinating data sharing with MCOs and ensuring accuracy of member completion rates

    - Quarterly member completion compliance reporting to CMS

    - Coordination of and staff time participating in workgroups to develop program implementation specifics

Retroactive Eligibility

Results from Key Stakeholders Interviews

Goals

Key stakeholders interviewed shared their understanding of the goals of the retroactive eligibility waiver in Iowa, which included the motivations listed below, along with stakeholder articulations of goals:

- **Encouraging proactive member enrollment**

  - *"As I understand the design, it was to promote people to buy in ahead of time."* – MCO representative

- **Response to fraud**

  - *"We understand that it was just some fraud clean-up. Some of it was just administrative burden of patients not getting the paperwork back to the provider, or provider not getting the paperwork back to Iowa Medicaid in a timely fashion."* – Provider group representative

- **Program level financial solvency**

  - *"I think there was probably some cost concern in it too…I know it's been re-extended to a couple of provider types. We don't necessarily get the total reason and rhyme for that and why not others, but we also know what the price tag was to re-extend to everybody, the fiscal note for the legislature. And that was not something that would be appealing to the legislature at that time. So, guess that's my basic understanding, assumptions of it."* – Provider group representative

- **Ensuring timely eligibility determination by providers (regarding abbreviated time frame)**

  - *"I think it was also a safety net that some providers perhaps misused at times, knowing they had that window in there and that they didn't have to necessarily push to check for eligibility or to check for other options for that person to afford their care."* – Provider group representative

- **Certifying that eligible beneficiaries receive coverage**

  - *"To make sure that the members who qualify for that benefit are getting that benefit."* – MCO representative

- **A mechanism for providers to be reimbursed for services rendered to uninsured people**

    - *"To pay the providers who are providing those services for members who qualify. So, in most cases, those members are qualifying because they have an event where they go to the hospital and that qualifies them. And so then, by way of that, then once they become eligible, the providers can be reimbursed for their cost."* – MCO representative

    - *"It helps them [providers] become paid, in the event that they wouldn't have been otherwise. Because the person has no insurance."* - Iowa Medicaid representative

- **Timely documentation of enrollee utilization patterns (regarding abbreviated time frame)**

    - *"It matters with regard to tracking utilization so that we know when there is an inpatient admission or another medical event that is taking place that makes someone eligible. You would rather know that right away and not be waiting five, six months to have that information. This is a, the sort of Medicaid 2.0 world we're in is a different mindset than just enrolling people in a benefit. It has to do with understanding what their costs and their health condition is on a day-to-day basis. And we really are trying to get up to speed to do that. The data management in this industry is very similar to every other industry right now. We want to know who is on our rolls and what they're experiencing on any given day."* – MCO representative

- **Promoting efficiency in the enrollment, care management, and reimbursement processes**

    - *"The tighter the retroactive timeframe, the more efficient it would be for a provider. And so, if you're working in a scenario where you have six months of retroactive eligibility, which is not what we have in place here, just from a provider perspective that's six months where, from an accounts receivable standpoint, they're carrying those balances on the books until they know where to bill appropriately. So, the tighter the timeframe, the more efficient ultimately."* – MCO representative

- **Provide a safety net for Medicaid-eligible uninsured people with a catastrophic health event**

    - *"It's just to help the individual. A lot of times something medically arises, and it helps them pay for that cost."* – Iowa Medicaid representative

    - *"I think the intended goal is if a health crisis comes up, and services are in place, that that eligibility for that service would be retroactive back to. It really works for the aging population who might have to go into a nursing home. Or a rehab facility, kind of figure out the details. A crisis occurs, a person has a stroke, they hadn't anticipated being in rehab or going into a nursing home. They make it retroactive back to the point of that crisis, is my understanding."* – Provider group representative

    - *"The spirit of retroactivity I think is right in that there's going to be times that you need to catch people after something's happened. That's probably more fair to the provider, and it's probably socially a little more just because some people... If you're just barely paying your bills, you're just not thinking about, "Hey, maybe I'll go try to buy insurance, or I'll try to qualify for Medicaid." You just may not have thought of that."* – MCO representative

- **Aligns enrollment window timeline (calendar month) with premium payments to MCOs**

    - *"Yeah. I believe, I think that the timelines are more associated with the Iowa Medicaid's enrollment eligibility process than it is anything else. So that's just basically they're cut off*

because when you think about when a member becomes eligible in a month, it drives the premium payments to the MCOs as well. And so, depending on what point of the month the member will become eligible, what drive, whether we receive premium for that month, partial premium, or one that cuts over. So, I know it's built in their mechanics a bit from that standpoint." – MCO representative

- Unsure of rationale or intent behind policy

  - *"I'm not sure, as far as, it was a legislative action that implemented the waiver of the retro policy. I guess that was just as part of my duties to implement the exceptions to who was allowed to have the retro coverage, and implement the policies as the legislative action described… I don't recall being involved in the reviews, or anything like that, that would've involved the fiscal analysis, or anything like that, that would've gave any historical information, or any explanation for why the bill was passed."* – Iowa Medicaid representative

Effectiveness

Stakeholders shared perceptions of how effective the retroactive eligibility waiver policy is in achieving its various goals, with some highlighting positive impacts, acknowledging challenges in application, and noting low levels of awareness amongst members.

A representative from Iowa Medicaid spoke to the positive impact for uninsured people gaining coverage to relieve financial burden from a medical crisis, saying, *"In general, it's a wonderful thing for people. Because it really helps them out when they're in a bad crunch. So, no, I haven't heard anything negative."* Along with a dearth of negative feedback, an Iowa Medicaid representative cited changes to benefit eligible populations as evidence for effectiveness, saying *"I would assume [policy effectiveness] because they gradually added populations back to allow retro that those were lessons learned, or there was feedback that contributed to making those changes."*

An MCO representative shared perceptions about retroactive coverage positively influencing future care utilization and behaviors, saying, *"[Does] giving people eligibility, even retroactive eligibility, motivates them to get insurance in the future and whatnot. I would probably say yes. Maybe their situation changes. They've maybe established care with the provider, and they see the importance of it, especially if they have a chronic issue. They probably realize, 'Hey, I thought I [was] healthy and immortal before I had this other issue that then got me on Medicaid, and now I need to think about that going forward.' I do think it probably does influence them."*

In regard to the ability of calendar month-limited retroactive coverage to influence member decisions to proactively enroll in Medicaid, two stakeholders perceived limited awareness amongst members, with an MCO representative saying, *"that distinction is, I don't think, common knowledge,"* and a provider association representative saying, *"I would say, across the board, patients have no idea."*

In response to whether the state has seen any cost saving impact from the retroactive eligibility waiver, a representative from Iowa Medicaid responded, *"That, I'm not sure. I don't have the numbers on that. So, I can't really say to that."*

Interviewees noted some areas in which the retroactive eligibility waiver intention could be compromised, including provider's ability to attend to enrollment logistics, situations in which an uninsured person could be incapacitated and unable to apply for enrollment in a timely fashion, and, generally, a provider association representative stated, *"I think the intent is good. I think that the implementation is still rather messy."*

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An MCO representative noted that health crises could potentially interfere with timely enrollment resulting in shifting enrollment responsibilities to another entity, saying, *"I think there's a possibility, it goes wrong for the person who has some catastrophic event again, who is not capable of doing the paperwork and has to rely on say an institution or a hospital to get it going."*

A provider association representative spoke to the limited capacity for providers to assist with timely enrollment to secure Medicaid funded reimbursement in the case of treating an unsured person, saying, *"I think it's an area where folks have gotten to be lax for a long time under pre-expansion and under pre-managed care. It's just, I think it's a return-on-investment question and a question about whether these provider systems have the staff resources to track some of the stuff down. I don't have a good answer to that… I think there's some room for improvement there, but again, you have to balance that with everything else."*

Supplementary efforts

Stakeholders talked about efforts which parallel or support the goals of retroactive eligibility, including general Medicaid expansion to more populations, concerted effort and investment in systems to maintain up-to-date eligibility data, provider-based staffing positions dedicated to enrollment, and provider education campaigns.

A representative from an MCO reported efforts to adhere to retroactive eligibility expectations through continuous management of member data by eligibility group, saying, *"We work very hard with the state to make sure our eligibility files are in line with theirs… that's what we do to mitigate the adverse impact of not implementing that part of the benefit, the limited retroactive eligibility, as well as the subgroup that is not limited. That becomes really important, that administrative function of keeping track of who's in, when are they coming in, when do they apply? A lot of energy gets put into that by our operations team."* In addition, a provider association representative described similar data management efforts internally, saying, *"We implemented a system that works in conjunction with their electronic medical records, where we are able to pull additional information inquiries on insurance and eligibility."* This representative added an opportunity for improvement to adopt quality improvement practices more widely to better confirm retroactive eligibility types, saying, *"for provider types across Iowa, there's probably some streamlining and some internal workflow they could do to improve that area."*

A provider association representative noted alternative, limited funding options to provide care to patients with unconfirmed Medicaid eligibility *"that ease that [risk of providing uncompensated care] a little bit for us,"* saying, *"we do have a little bit of a safety net through our federal [funding source]. So, are built in a little bit to be able to cover some of those gaps for retroactive coverage and for patients who don't have insurance until we determine their eligibility, a little better than some other provider types do…we can backfill that uncompensated care, but that federal fund almost always runs out before the year is over."*

Finally, a provider association representative described efforts to educate providers about managing care for patients with limited retroactive eligibility, noting initial reservations about the policy from providers, saying, *"when the [retroactive eligibility waiver] policy was in place, we did a major education push with our folks [providers]. They weren't happy about it. They've adapted. We are a little bit more unique scenario, I think, than other provider types, where we do have ability to write some of it off."*

Enrollment

Stakeholders shared perspectives about the Medicaid enrollment process within the scope of the retroactive eligibility waiver, noting the various roles and steps involved. Interviewees reported hospital-based advocates, MCO case managers, administrative positions, community health workers,

hospital social workers, healthcare staff and socialized enrollment staff as having roles in guiding newly identified eligible members through the enrollment process and maintaining related records.

One provider association representative described the staff involved in implementing retroactive coverage, saying, *"in our smaller [provider settings], it's much more likely to be a provider or administrative position [managing enrollment]. In our larger [provider settings], a lot of those have hired social workers, community health workers, or just enrollment staff. And a lot of those enrollment staff assist with just the day-to-day insurance checks and eligibility checks."*

A representative from Iowa Medicaid noted that typically, MCO case workers would be relied upon for care coordination tasks, but people in the process of applying for retroactive coverage don't have access to that support, saying, *"If they're enrolled in MCO, the case management on medical management will work with social workers at the hospital to assist in any of those needs [enrollment]. But if they're not enrolled, then I'm not sure."*

A provider association representative reported efforts to connect patients with a provider once coverage is verified, saying, *"their [health care staff] goal with the patients, if they can, is to make sure they're enrolled, then that they know that they have coverage, and then get them into some kind of treatment plan and work to get them back in a timely fashion. And once a patient comes in, they try really hard to make sure that they understand if the patient is eligible and help them get into that."*

Representatives from both MCOs acknowledged the expectation of provider intervention in assisting uninsured individuals in the prerequisite enrollment process for retroactive coverage, saying,

> *"Different providers have varying levels of sophistication about enrolling Medicaid. If you're a hospital and somebody has no insurance, they come in and they maybe had something pretty major, the hospitals are pretty motivated to see if they can't qualify for Medicaid. They lead the process there, but other providers may not be that sophisticated and motivated, and so then the members end up getting medical bills they can't pay or something. Then it doesn't go quite as well.*

> In response to the question, "Do you think this has any kind of impact on provider workflow or administrative burden?" an MCO representative replied, *"I'm sure it does. I don't hear about that as much from providers, but I can't imagine it wouldn't. Because they're trying to make sure that those members are getting the paperwork in with Iowa Medicaid to get the eligibility that they need. I'm not familiar with the ins and outs of the process, but it would be work on their end for sure."*

In contrast, a representative from Iowa Medicaid, denied provider involvement prior to confirmation of Medicaid eligibility, saying, *"Generally, providers aren't involved until we know that the member is eligible, of course. If they're working together, if there's a miss, as far as the potential for retroactive eligibility, and it didn't happen at the time of application, then we might have some provider involvement in it at that point, but generally not do the providers."* This account from Iowa Medicaid of providers not being involved in enrollment processes conflicts with MCO and provider association representative accounts in which healthcare providers reportedly do assist with verifying eligibility and initiating enrollment.

An Iowa Medicaid representative talked about how various positions interact to verify Medicaid eligibility and coverage, saying, *"the enrollment process, well, it's kicked off by the members' application, of course, but then it's our field operations, and income maintenance field staff that process the applications."*

Interviewees reported about the various eligibility categories within the retroactive eligibility waiver, noting the difference between coverage for members who are and are not eligible for 90-day retroactive

eligibility. A representative from Iowa Medicaid elaborated, saying, *"If they're not eligible for retroactive coverage, the notice of decision that we send indicating approval would just be effective the month of application…Their effective date, if they're approved, then their effective date of eligibility would be reflected, whether it be one, or all three months of the retroactive coverage, or just from the month of application forward, because they don't meet the criteria to be eligible for retroactive coverage."*

Member experience

Key stakeholders described interactions with members related to the administration of the retroactive eligibility waiver and levels of member awareness and engagement.

A representative from Iowa Medicaid described the categorical eligibility policy as so nuanced that it is difficult to communicate to members en masse, saying, *"I don't know that there's anything on the website specific to retroactive eligibility. I think it's more just part of the application process, since it's so specific to either age or other requirements."*

Representatives from an MCO and provider association elaborated that the intention of retroactive eligibility waiver to encourage proactive enrollment amongst eligible populations may lack effectiveness due to a complex design, more immediate competing priorities, and a general lack of awareness of potential eligibility, saying:

> *"That would make sense. I mean, that might be how I would think about it. I don't know if that's how the average person who's eligible for the Iowa Health and Wellness Plan thinks about it, but I understand the design."* — MCO representative

> *"If you're just barely paying your bills, you're just not thinking about, "Hey, maybe I'll go try to buy insurance, or I'll try to qualify for Medicaid." You just may not have thought of that."* — MCO representative

> *"Just by the nature that folks don't always know that those items can be covered by Medicaid…a lot of times, they don't know that they have those benefits."* — Provider Group representative

Spillover effects

In prior sections of the key stakeholder interview findings, several spillover effects (e.g., impacts not directly intended by the policy) related to the retroactive eligibility waiver for the IHAWP members emerge from the content, described below:

A representative from a provider association discussed the role of providers and clinic staff in operationalizing retroactive eligibility, reporting that providers are burdened with additional administrative work to verify member eligibility and funding care at the time of service, describing the process as, *"back sorting through a lot of paperwork"* and *"navigating a number of players involved in getting reimbursement."* This representative continued, noting challenges assessing eligibility with patients unfamiliar with Medicaid and lacking information needed to determine eligibility.

Illustrations of the provider experience follow:

> *"We also have a patient population which I would say it's harder to get that stuff out of. and it's just not a population like you and I, who has at our fingertips and can scan it or send it in or whatever. So, I think that puts some burdens on our providers as well."*

> *"A lot of times, they [uninsured patients] don't know that they have those benefits and don't communicate that possibly to a center and then they are treated as a slide patient…from what I've seen, we probably have a*

bigger risk of missing somebody or using that money and finding out there's coverage later… Just by the nature that folks don't always know that those items can be covered by Medicaid."

"You asked a question about providers being paid. From our perspective, that continues to be an issue. Providers are having to reach out to their associations to get help. If there is an issue where the service plan is not developed in authorizations, dated as such…any work that's done is after the fact, and it is to adjust for decisions that have been made and denials for payment…and it is still a bit of a struggle, I think that the MCO staff on the ground are willing to work with us, but that is not the way the system is set up."

A provider association representative described their response to challenges and barriers encountered while navigating retroactive eligibility waiver, saying staff has *"to go back and do the legwork themselves, but we can at least say, "Hey, you have this, let's say, 20% of your population that hasn't given you any updates as to what their insurance is. And you have nothing on file as to what their family income is either. What workflows can we help you put in place to help winnow through that list a little better and get that list a little bit more accurate." Of course, then you're just always still riding up against our patient population and also staff resources too."* The representative also noted, *"we do have a little bit more of a hands-on approach with some of our patients, that maybe that continuity issue isn't lost as much, thanks to our staff."*

Representatives from an MCO and provider association talked about the challenge for an uninsured individual in crisis and the capacity to prioritize enrollment, saying, *"I think there's a possibility, it goes wrong for the person who has some catastrophic event again, who is not capable of doing the paperwork and has to rely on say an institution or a hospital to get it going"* and *"the patient population sometimes has more needs and are sicker, and so, can put a little bit of a strain on the centers in wanting to be able to provide all the services that they need and that kind of stuff."*

In sum, providers navigate the following steps (within a calendar-month limited time frame) to adhere to the adjustment to the reimbursement cycle resulting from the waiver of retroactive eligibility when a member is seeking care and is unaware of insurance status:

- o Provision of care is prioritized
    - o May utilize alternative funding or provide uncompensated care (absorbing costs)
    - o In the case that Medicaid eligibility is confirmed after service, providers
        - ▪ Submit Medicaid claim
            - • Process of gaining authorization for claim, potential for denials and resubmissions
        - ▪ Potential inappropriate use of alternative funding (requiring reversal of payment or unnecessary diminishment of limited funding)

Cost Sharing

Results from Key Stakeholders Interviews

Goals

Interviewees shared perceptions of the goals of cost sharing, mentioning the following intentions of soliciting a copay from members in the case of nonemergent ER use:

- **Deterring utilization of the emergency room for nonemergent complaints or routine care**
  - *"I think it's a deterrent to going to the emergency room when you don't need to. I mean, I think that's really very simply put. That's the intent."* – MCO representative
  - *"Just to keep members from using the emergency room as their primary care."* – MCO representative
  - *"I think probably the goal of that is that Medicaid members would not use the emergency room for their doctors' visits."* – Provider Group representative
  - *"Decrease inappropriate use of those locations."* – Provider Group representative
  - *"Part of the goal is just to minimize some of those ER trips that may not be needed."* – Iowa Medicaid representative

- **Creating a point of intervention to educate members and direct them to more appropriate care settings**
  - *"I think it is intended to redirect to their primary care physician."* – MCO representative
  - *"To help increase education of patients about what is inappropriate use of an emergency room or urgent care."* – Provider Group representative
  - *"Help educate patients to the benefits they're eligible for and encouraging them to find a health home."* – Provider Group representative
  - *"Well, I think that's part of the goal exactly. Is that it's preventable. And in hopes that maybe people would go to a clinic instead, or a telehealth right now there's so many options. You could even do telehealth if it was after hours."* – Iowa Medicaid representative

    Decisions about the continuation of Iowa's telehealth flexibilities after the Public Health Emergency (PHE), is under development. As of December 2021, the state shared that "Some expanded telehealth codes may be recommended to continue post-PHE." (1)

    In a follow-up question about telehealth access for members (as an alternative to emergency room care), an Iowa Medicaid representative expressed some uncertainty of IHAWP member coverage and access to telehealth services, saying, *"I don't really have an answer for that. I'm not really sure. I believe it is covered. It's just like a regular doctor's appointment. I'm not sure. Well, I know it's covered…But I'm not sure, what that looks like."*

- **Promote awareness of healthcare costs to members and set the expectation to financially contribute to healthcare services (in alignment with private coverage)**
  - *"I do think that there was a goal to try to make it feel like commercial insurance."* – MCO representative
  - *"Yeah. I think the other thing too is if the thought is, "Hey, this gives them coverage. Maybe one day they do get a job that does have health insurance," in some ways it's training you a little bit, Hey, if you end up getting insurance, there are these copays, and here's how it works, so it's not such a feeling of shock when it's like, "What? ER's aren't free?" It's, "Yeah, they cost something with normal insurance." I think it gives people a feeling that they have insurance, that they've contributed to their insurance."* – MCO representative

- *"I think that it's intended to highlight the value and cost of using the emergency care, especially for non-emergent services or conditions, and help people understand the emergency room is a high intensity location of care. Because of the overhead to provide that intensity, it ends up being a very expensive way to get services. I'd say that most copays are designed around helping people understand that there are costs to seeking services and getting services. I think copays are intended to help them better understand the costs involved."* – MCO representative

- **Reduce emergency room provider burden**

  - *"Our providers, pretty tough businesses around, especially in this environment. And so, for them, they need to make sure that everybody that's coming in that, that care level is appropriate, that they're not being overburdened in their emergency rooms by inappropriate use."* – MCO representative

Effectiveness

Interviewees shared perceptions about the effectiveness of cost sharing and conveyed skepticism about its impact on emergency room use.

One MCO representative compared the effectiveness of the cost sharing expectation to other efforts, favoring member education, saying, *"Whether it's [cost sharing] effective, and I think you'd probably hear us pretty unanimously say, no. I mean, that's not a deterrent ultimately. So, we rely on our other program options and member education and engagement to try to affect that ER utilization to make sure it's appropriate. But yeah, I would agree. It's definitely in place to be a deterrent and the effectiveness piece, that's a different line of conversation."* A provider association representative shared preferences for the efficacy of member education, saying, *"I think a lot of our providers in a philosophical-only world would say, a penalty is not the right way to reduce ER visits and increase patient education. They'd rather see it go towards patient education and encouragement of health homes. I think they get it, and they get frustrated too when patients go to the emergency room, when not only we could have treated it cheaper, but also, it would've been a great education opportunity for us."*

Perceptions of the validity of cost sharing as an emergency room deterrent were not widely supported, with interviewees unsure of evidence of effectiveness in practice or in research. One MCO representative said, *"I don't know who's in the Iowa Health and Wellness Plan or not, they use a lot of emergency room care…If there's a disincentive, I don't see it in that practice"* and a provider association representative shared, *"They [state work group] did some study on it and I think they found there was a slight deterrent to it, but beyond that, all I know is anecdotal."* Another provider association representative added perceptions of effectiveness, saying, *"I do think that overall, it probably has had an impact. I don't have specific detail, but what I have heard is that it has had an impact with fewer people using the emergency room as their primary care."*

One MCO representative framed the efficacy of a copay within the broader complexities driving unnecessary ER use, saying, *"it's actually a much, much bigger question than it sounds, because what's the member's situation? What's their diagnosis? What challenges are they experiencing? All those things drive the intervention methods."*

$8 copay

Within the conversation about the effectiveness of the co-pay, stakeholders commented on the amount of the co-pay charged ($8) and perceptions about that amount, with one MCO representative saying, *"I*

respect the amount. It's not a lot, but I think it's more than five bucks. It's more than a buck. It's enough to... It's $8. It's almost awkward. You almost have to think about it. Oh, I need to give you five and three?"

MCO representatives doubted the impact of the $8 copay, suggesting the amount was too nominal to impact member decision-making or incentivize enforcement, saying:

- *"I will say that it's been my observation historically, whether $8 is an effective deterrent or not. It's $8. It's $8. And then again, does the emergency room even try to collect it, how they use it…I would not say $8 is a material enough of a number to probably have an impact on that one way or the other."* – MCO representative

- *"Now, if an $8 copay has a negative impact or deterrent there, I don't believe so. I really don't."* – MCO representative

Regarding whether an $8 copay is substantive enough, stakeholders suggested that for low-income members, the amount could be effective in decisions about type of care, saying:

- *"$8 doesn't sound like a lot for someone that's working, but for someone who is not working, it may be impactful, and it may make them think twice."* – MCO representative

- *"I think it's an interesting amount, and I don't know if it works in the Iowa Health and Wellness Program, but I am pretty confident that copays work in terms of helping people think through their decisions about do I go, or do I not go?"* – MCO representative

Representatives from Iowa Medicaid and an MCO shared perceptions about whether a copay might interfere with necessary use of the emergency room, reporting that $8 was unlikely to cause financial strain or a barrier to needed care.

- *"Even prior to PHE, we never really heard any complaints about it or any hardship things."* – Iowa Medicaid representative

- *"I worry a lot about copays, especially in emergent care. I think there's been enough research that says when a copay gets hefty enough, it can discourage people from early presentation of serious emergent care. I think the state put a lot of thought into what's too hefty and what's not hefty enough. I don't know the right answer, but $8 certainly seems like something that would get me thinking, but is also probably not a serious... barrier is too strong a word, but stepping stone... It's not a serious barrier to seeking care when you really need it."* – Iowa Medicaid representative

Enforcement

While cost sharing copays were waived during this evaluation period as a PHE flexibility, interview respondents reflected on the collection of copays pursuant to the behavior change goals of cost sharing.

One element of the enforcement of Iowa's cost sharing waiver is the acceptance of what constitutes an emergency, with a stakeholder from an MCO describing the definition developed by the state[1] as disputable, saying, *"The Iowa Medicaid enterprise has a very specific way of defining an emergency... I'm not sure it's universally accepted. It's the way we do it, and I understand why we do it. I also can see how it's so specific that a person could just fundamentally say, "I disagree. Of course, it was an emergency." I think that there's a lot of potential opportunity to debate what's an emergency in the Iowa Medicaid Enterprise benefit."*

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[1] ICD-10, ICD-9

The Iowa Medicaid definition of an emergency is derived from claims codes, as one MCO representative described, *"it's more driven by diagnosis code used on the claims, and Iowa Medicaid determines what's considered an emergency from a diagnosis code perspective, and then the MCOs use that."* An MCO representative added detail about using the claims codes to reimburse providers at a reduced rate for non-emergent care provided, *"we deduct the copay amount that they should be collecting from the claim payment side of it."* Another MCO representative illustrated, *"So fast math, if it was a hundred-dollar bill, in that circumstance, an ER visit is not a hundred dollars, but just for ease of math, we would reimburse the provider $92 because we know there's an $8 cost in effect there."* Figure 5 shows the cost sharing process and various roles stakeholders have in implementation.

Figure 5. Cost Sharing Process as described by Key Stakeholders
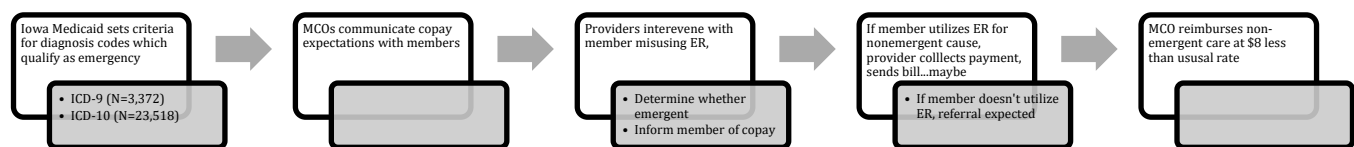
A representative from Iowa Medicaid suggested that member utilization of emergency care is generally validated by providers, avoiding the imposition of a copay altogether, saying, *"I think they are seen and, it sounds me, which I'm not real sure that there aren't very many that end up even owing that $8. I don't know numbers…Typically the hospital does not deem it as not an emergency."*

Regarding the motivation of providers to enforce cost sharing and solicit copays from members, stakeholders acknowledged wide recognition of inefficiency, noting that the nominal amount of money to collect is not worthwhile for providers. One MCO stakeholder summarized, saying, *"ultimately a provider would be in the best position to answer that question because they're the one that would be collecting the copay or the cost share. I think from their experience and whether or not they actually collect them or not, or they simply waive it."* Additionally, stakeholders report in cases that members don't pay the copay at time of admission, providers absorb the copay charged to members rather than collecting payment via billing, a decision which could vary by hospital size.

- *"It's not widely used. That it is at the discretion of the hospital. And they often do not seek that $8 reimbursement."* – Iowa Medicaid representative

- *"In terms of, if the provider actually goes and gets the $8, we really don't know. Presume not, because it's not worth the time to chase it. They're probably just writing it off is my guess. Yeah."* – MCO representative

- *"The estimate is that it cost about $9 to send a bill out. It's not uncommon for some providers to say, "If they didn't pay upfront, is it even worth sending a bill," or is there a level at which you write things off because it's costs more to try to collect it? Everybody has a different level. Is it at $5? Is it $8 or something? Depending on the healthcare organization, and again with the ER, typically you are not allowed to refuse service if they don't have the copay with them at the time, so I'm sure there are some that may make that as that it's not worth sending the bill out."* – MCO representative

- *"I think sometimes the hospitals have a hard time even collecting the $8. So, just because of all of the issues that come with it, patients won't always come in with the $8, and so you can't get it. And then when you go to bill them, there are lots of things that can happen just in that part of it."* – Provider group representative

A provider association representative suggested that better tracking of payments and follow-through from providers would be needed to understand the effectiveness of cost sharing, saying, *"I think that to answer that question really well, you'd have to see some kind of data on how often it's collected, as to compared to how many times is it paid and how many times should have been paid, would give you a better information than anything else."*

Supplementary efforts

Stakeholders talked about efforts which parallel or support the goals of cost sharing, including member education campaigns, case management, targeting high-utilizing emergency room (ER) members through claims and HRA data analysis, expansion of care access options, and alignment with value-based reimbursement models.

A representative from Iowa Medicaid noted the deterring impact of the COVID-19 pandemic on unnecessary ER use, noting lengthy patient wait times and limited capacity of emergency rooms to provide care, saying, *"I think that right now ERs are so full anyway with the pandemic. I don't think people are getting in there for things that they don't want to wait a long time, which typically would be an emergency. I don't think it's being utilized incorrectly in that sense. Because it is so hard to get in right now."*

Provider expansion of after-hours care access and preemptive contact options (translation included)

- *"I mean we try to discourage emergency room visits whenever possible. As a primary care provider, not an emergency or urgent care provider, we try to make sure that those patients have every opportunity to reach out to us first. We have after-hours lines, we have extended service beyond nine to five, we try to get folks to use portals for their electronic health records to be able to message their provider, and we have translators and community health workers that we try to backfill that with."* – Provider group representative

Intervening with individual members to encourage routine care via case management

- *"The HRA assessment…. a screening type tool to see what their score was to see if they could benefit from case management services. And that was a component that helped assist with that high utilization. If we enrolled you in case management, we could be taking care of these concerns ahead of time keeping you at out of the ER, getting you appointments as needed. And then building in care plans to address all those different areas. So, they were making sure that they were getting things treated before having to always go to the ER."* – Iowa Medicaid representative

- *"I would say that if there's repetitive utilization, yes, there is engagement there… we do monitor those that have excessive ER utilization. And again, if we see that there's a more appropriate setting for them receiving their care, obviously we're going to work with them directly to make sure they're educated about all their resources…Are they engaged with their primary care physician? Are they getting that routine care delivery done in place or are they not receiving that care at all? And so those are how those components will manifest there, but we do have processes in place today. Probably the biggest, if they're really, really frequently using the ER, case management is absolutely where we're going to try to get that member engaged."* – MCO representative

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Leveraging data analytics (utilization /claims data, Admission, Discharge, Transfer (ADT) alerts) to monitor and respond to ER use risk

Representatives from Iowa Medicaid and an MCO mentioned the use of PatientPing (now Bamboo Health) to share Admission, Discharge, Transfer (ADT) data across provider types, with an MCO representative saying, *"there's claims data. We've become connected. Oh gosh, what's it called? PatientPing."* A representative from Iowa Medicaid elaborated, saying, *"I know MCOs use some programs that help them identify high emergency room utilization. And there's a program called PatientPing that I know Iowa Total Care use. That sends us a report every single day on members that presented to the ER. And then from that point, that would trigger a referral to our medical management department. Where our medical management team would actually reach out to that member."*

A provider association representative talked about internal efforts to address ER utilization, saying, *"I think it was just one of those initiatives that came out of some work that our analytics people were doing. And trying to keep people out of the emergency rooms, what can we do to help with that? But it didn't have anything to do with the fact that they might have to pay."*

Education and awareness campaigns with members

Representatives from MCOs and provider associations described various initiatives to educate members about appropriate care use and encourage contacting a provider before going to the emergency room, for example:

- *"I think the more effective approach is everything else that's in place today, member education, how we handle when members outreach to us and they need care, how we're supporting where they go for that care."* – MCO representative

- *"I think the centers did all that work, just trying to educate patients, that "Call me first." They had a lot of signs and patient swag. Had a bracelet that said, "Call me first rather than going to your emergency room." So, trying to help them understand that that's better for them and it's better for just everybody if they would make that call first rather than going there. So, how much it deters, I don't know."* – Provider group representative

Alignment with value-based payment models

- *"It was more of, I think, as we were moving towards this value-based care or these contracts, we knew that that cost could affect how we get paid. And so, keeping people out of the emergency room came out of that."* – Provider group representative

- *"Providers' efforts, which are always embroiled. This is always a key in our value-based arrangements with the health systems and providers across the state. So, there are many, many, many, many, many tactics in place to help effect an ER diversion."* – MCO representative

Member experience

Key stakeholders described interactions with members related to the administration of the retroactive eligibility waiver and levels of member awareness and engagement.

Limited awareness of copay

- *"I will say the other thing we have heard is, most of the time the patients don't know there's an $8 copay. I would say their education on that comes from our health centers with the Call Me First stuff if it comes from anywhere.*" – Provider group representative

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Reluctance to enforce copay or referral because of consequences of delayed or denied member care

- *"I would say we generally hear that the patients are not turned away. I think there's a lot of fear, especially in COVID world, of turning a patient away when your guess is it's probably not urgent, but you also don't want to risk any liability. We hear though people waiting extremely long amounts of time, even pre-COVID, in the emergency room when they were a health center patient or a Medicaid patient or whatnot. And were there perhaps not for the best reasoning or because they waited too long, and what they had, turned into a big issue."* – Provider group representative

Copay presents a potential financial stressor for low-resourced members

- *"$8 doesn't sound like a lot for someone that's working, but for someone who is not working, it may be impactful, and it may make them think twice."* – MCO representative

Spillover effects

In prior sections of the key stakeholder interview findings, several spillover effects (e.g., impacts not directly intended by the policy) related to cost sharing for the IHAWP members emerge from the content. Spillover effects of cost sharing primarily impact providers, as outlined below, and summarized in the following statement from an MCO representative:

"The point of intervention there doesn't involve the MCO, that involves the provider. And so, what the provider's practice is, and whether they choose to accept it or not. Let's not forget if it's an emergency, the provider is legally obligated to treat the member. So quite frankly, whether the member has $8 in their pocket or not, they have to be treated. And so, I think that's probably from a provider's perspective, that's probably a bit of a burden for them because they have to treat regardless of the emergency setting. And now there's that co-payment out there, the level of effort that a provider would put into collecting an $8 bill for a member that's visited the ER, I don't know, I can't speak for them, but that feels like a law of diminishing returns in my mind to some extent there."

Providers:

- Within the cost sharing administration, providers are charged with the following responsibilities (see Figures 5 and 7):
  - Intervention with member to divert from ER
    - Assess member symptoms
      - Cross-reference Iowa Medicaid approved emergency diagnosis codes to determine whether emergent
    - Inform member of copay
    - Refer to alternative care and verify access to alternative care
  - Collection of copays at time of service or disbursement of a bill
- In addition to responsibilities, provider incur the following risks:
  - Receipt of reduced reimbursements regardless of successful collection of $8 from members
  - Risk liability in unintentionally diverting emergent care Members:

In addition, generalizations about emergency room usage by IHAWP member could cause potential invalidation of an IHAWP members choice of care provision for their health concerns, as illustrated by a comment from an MCO presentative, saying, *"I don't know who's in the Iowa Health and Wellness Plan or not, they use a lot of emergency room care. That's very anecdotal of course, but they're homeless, and they are in and out of the emergency room. If there's a disincentive, I don't see it in that practice."*

Methods

The IHAWP evaluation plan included a process evaluation to document and describe the implementation of IHAWP and its components. The process evaluation used primary and secondary data sources to determine the adherence to the strategies and plans as described in IHAWP program.

The process evaluation examined the governance and execution of the IHAWP to provide context about the effectiveness of programming as measured by outcome metrics described in other parts of the evaluation plan. In addition, findings from the process evaluation may be used to improve outcome measures of the evaluation, such as informing language in survey items.

The two types of data sources integral to the process evaluation are outlined below. Secondary and primary data sources were coalesced to create a comprehensive depiction of the functions and management of IHAWP. The synthesis of these sources provide insight into programming vision, perceptions, governance dynamics, communication and management practices which have implications for the outcomes and strategic direction of IHAWP. Process measures were designed to describe the state of the program or some aspect of the program, but do not lend themselves to testing.

Environmental Scan

Existing documents produced for IHAWP implementation were monitored, compiled and synthesized by PPC staff to track progress and diversions from original program description and objectives, a process known as an environmental scan. The content of these documents provided sources to identify and recruit stakeholders for structured interviews included in the process evaluation. In addition, information unable to be gathered from the environmental scan determined which outcome areas were included in qualitative data collection.

Environmental scan data sources:

- Waiver documents
- Quarterly progress reports
- Meeting minutes
- Supplemental materials from relevant advisory groups or committees
- Informational letters
- Contract and RFP documents
- Internal planning documents

Structured Key Stakeholder Interviews

Interviews with key stakeholders with executive leadership were conducted and more stakeholder interviews with various groups (e.g., Medicaid providers) will be staggered at different times throughout the evaluation. For this report, stakeholders in executive leadership positions were interviewed from the following three groups involved in IHAWP implementation:

1. Managed Care Organizations (Amerigroup and Iowa Total Care)

2. State Medicaid Agency (Iowa Medicaid)

3. Two statewide provider associations

Interviews were about 60 minutes long and topics for the structured interviews were developed to reflect the content of each program and target any areas which were not covered in the environmental scan or could benefit from elaboration from a primary source. Interview results will be used to provide context for data collection activities, outline the availability of key pieces of information and document adjustments to IHAWP. Stakeholder interviews may occur at varying times as needed for the areas of emphasis.

A single interviewer from the IHAWP evaluation team conducted interviews over video conference (Skype). Video calls were audio recorded and professionally transcribed. The interviews transcripts were uploaded into qualitative analysis software (NVivo) and coded into themes by a single coder. Some themes were pre-determined according to the structured script, and some were emergent and reflect the natural flow of conversations and provide additional context for the structured conversation.

Appendix A. MCO Health Risk Assessment Survey Crosswalk

The following table captures item-level similarities across HRAs administered by MCOs. Iowa Total Care administers two survey instruments (Iowa Total Care HRA and Iowa Total Care Supplemental HRA). An Iowa Total Care representative reported that members complete both instruments. Across the two MCO assessments (including ITC supplemental assessment), 84 total survey items are included. Of these, 24 items share identical item wording, 24 items were topically similar, but used unique language, and 36 items across both surveys were not captured in the HRA of the other MCO.

Identical items in HRA (N=24)	Comparable concepts captured, different items (N=24)	No comparable concept in other HRAs (N=36)

Legend

	Amerigroup HRA	Iowa Total Care (ITC) HRA	ITC Supplemental HRA
Demographics			
Race	yellow	yellow	
Gender	yellow	yellow	
Level of Education		gray	
Vision, hearing, speech accommodation needed		gray	
Employment status	green	yellow	green
Health impact on ability to work	yellow	yellow	
Self-rated health	yellow	yellow	
Program enrollment		green	green
Healthcare utilization			
Identification of PCP	yellow	yellow	
Primary/wellness visit	yellow	yellow	
Routine exams (colonoscopy, pap smear, mammogram)	yellow		
Dental visit	yellow		
Unmet need (dental)	green		green
Barriers to care (dental)	gray		
Emergent use (dental)	green		green
Specialty care	gray		
Emergency room	yellow	yellow	
Hospitalization	yellow	yellow	
Acute care		gray	
Post-ER visit		gray	
Post-hospitalization visit		gray	
Flu shot	yellow	yellow	
Prescription medication	yellow	yellow	
Barriers to medication adherence		gray	
Social Determinants			

	Amerigroup HRA	Iowa Total Care (ITC) HRA	ITC Supplemental HRA
Meeting basic daily needs	yellow	yellow	
Food (unmet need)	green	yellow	green
Childcare (unmet need)	green		green
Clothing (unmet need)	green		green
Dental care (unmet need)	green		green
Eye care (unmet need)	green		green
Medical care (unmet need)	green		green
Mental health care (unmet need)	green		green
Phone (unmet need)	green	yellow	green
Utilities (unmet need)	green		green
Transportation (unmet need)	green		green
Barriers to care (transportation)	green	yellow	green
Household size	green		green
Housing situation	green	yellow	green
Neighborhood safety	green		green
Social safety		gray	
Primary caregiver		gray	
Social engagement	gray		
Health management confidence	green	green	
Fear of partner	green		green
Chronic conditions			
History of chronic conditions (heart disease, asthma, high blood pressure, pre-diabetes, other)	green	green	
History of chronic conditions (cancer, respiratory illness, diabetes)	yellow	yellow	
History of chronic conditions (back pain, behavioral health)	gray		
History of chronic conditions (kidney disease, hepatitis, high cholesterol, HIV, learning disability, sickle cell disease, stroke, transplant)		gray	
Chronic condition care provider	gray		
Health impact on daily activities		gray	
Mental Health			
Symptoms (little interest in doing things, feeling down, depressed, or hopeless)	yellow	yellow	
Symptoms (loneliness)		gray	
Symptoms (stress, substance use)	gray		
Mental health diagnosis		gray	
Level of stress	green		green
Stress impact and management		gray	
Life satisfaction		gray	
Mental health hospitalization		gray	
Mental health treatment		gray	
Health Behaviors			
Tobacco use	yellow	yellow	

	Amerigroup HRA	Iowa Total Care (ITC) HRA	ITC Supplemental HRA
Tobacco cessation interest	yellow	yellow	
Healthy diet	yellow	yellow	
Exercise / physical activity	yellow	yellow	
Weight management	yellow	yellow	
Sleep issues		gray	
Recreational prescription drug use	yellow	yellow	
Illegal drug use		gray	
Substance use history	yellow	yellow	
Substance use treatment history	yellow	yellow	
Alcohol use		gray	
Substance use treatment need	gray		
Health literacy	green		green
Seatbelt use	yellow	yellow	
Attitudes (optional) (family focus, attentive to health, inclination to seek care for minor conditions, money management, personal health research, health planning)		gray	
Daily Living Limitations			
Assistance needed (bathing, dressing, eating)	green	green	
Assistance needed (taking medicines)	gray		
Assistance needed (walking, getting out of a chair, going to the bathroom)		gray	
Ability to complete activities of daily living (walking, laying, sitting, eating, bathing, dressing, using bathroom, bladder and bowel function, current assistance status, assistance needed)		gray	
Self-rated pain		gray	
Pain impact on daily living		gray	
Pain impact on social and recreational activity		gray	
Pain impact on ability to work		gray	
Pain intensity		gray	
Pain duration		gray	

Appendix B. Key Stakeholder Interview Script

Hello, am I speaking with [interviewee name]?
[if Yes, continue]
Is this still a good time to complete an interview?
[if Yes, continue]

My name is [research team member] and I am a member of the research team at the University of Iowa. Thank you again for your time. The goal of this study is to understand the impact of the Iowa Health and Wellness Plan from the perspectives of those involved in implementation. The purpose of this interview is to learn how the program works and what your experience in the program has been like. There are no wrong answers, we are interested in your opinion and experience.

During the interview, you can provide as much or as little information as desired, and any question can be skipped.

To accurately represent your responses, the interview will be recorded and transcribed. We will then delete the recording after the transcription process is complete. If we write a report about this study, your responses will be de-identified.

We anticipate this interview to take about (/maximum) 60 minutes. You can stop the interview at any time. Do you agree to participate?

[If yes continue]
Do you have any questions before we begin?
[If no, continue]
[If yes, answer questions/ take notes and follow-up if not comfortable answering]
Ok, I will start recording now.

I.   General
   a.   [For IPCA, IACP, MCO reps] How often does your organization interact with Iowa Medicaid staff? How satisfied is your organization with the amount of interaction with Iowa Medicaid staff?
   b.   What kinds of people are involved in the policy and program decisions related to Iowa Medicaid? (Staff, legislators, workgroups or advisory committees?)
   c.   What are the highlights or achievements of Iowa's IHAWP program?
   d.   What practices or resources are needed to improve Iowa's IHAWP program?
      i.   Prompt: *data collection, standardization, reimbursement, communication with providers and members?*

II. Retroactive Eligibility

   a.   What is your understanding of the goals of retroactive eligibility provision waiver in Iowa?

   b.   How does your organization perceive retroactive eligibility to impact …?
        Payers? Providers? (Time spent completing enrollment paperwork?) State of Iowa?
        Members?

c. Are you aware of any unintended consequences of retroactive eligibility policy? Does your organization do anything to address or mitigate impacts?

III. Cost Sharing

Medicaid members covered through Iowa Health and Wellness Plan are expected to pay an $8 copay at the emergency room if they are seen for something that is not considered an emergency.

    a. What is your understanding of the goals of the $8 ED copayment?

    b. How does your organization perceive cost sharing to impact …?
       Payers? Providers? State of Iowa? Members?
           Healthcare utilization (deter ED use?) and health outcomes of individuals?

    c. Are you aware of any unintended consequences of the copayment? Does your organization do anything to address or mitigate impacts?

IV. Healthy Behaviors

    a. What is your understanding of the goals of Healthy Behaviors Incentive program in Iowa?

    b. How do MCO-specific healthy behavior programs (My Health Pays from ITC and Healthy Rewards program from Amerigroup) interact with the state's Healthy Behavior requirements (wellness exam and completion of HRA)?

    c. How does your organization perceive HBI's impact on…?
       Payers? Providers? State of Iowa? Members? (Healthcare utilization?)

    d. What strategies have been used to increase awareness of and participation in healthy behavior programs?

        i. Any strategies to address disparities in completion?

    e. Walk me through the member experience.

        i. How is the IHAWP HBI program communicated?

        ii. What options to members have to access the HRA? Any reminders to complete?

        iii. What is done with the data collected? Is the data used or shared?

        iv. Same questions with MCO-specific program (also ask for copy of HRA)

    f. Do you anticipate any communication efforts for beyond the Public Health Emergency to inform members and providers about any changes to expectations (e.g., re-instating disenrollment)?

V. Transportation / NEMT

    a. What role does reliable and affordable transportation options have in healthcare?

        i. Prompt: is this a barrier to accessing routine primary (non-emergency) care?

        ii. What barriers in addressing this barrier? What data do you collect or tracking metrics (if any) about burden of transportation?

            1. Any information on missed appointments due to transportation?

        iii. Disparities by disability? Or location?

    b. What strategies, if any, has your organization employed to address transportation needs of IHAWP members?

    c. Do Amerigroup and ITC (Centene) provide private insurance in Iowa? What is coverage like? Transportation?

VI. Is there anything else that you have been thinking of and haven't had a chance to say?

Appendix C. Key Stakeholder Interview Codebook

Name	Description
Policy Area (Retroactive Eligibility / Cost Sharing / NEMT /HBI)	Comments about Iowa Medicaid's [Retroactive Eligibility / Cost Sharing / NEMT /HBI] program, including the annual wellness exam and health risk assessment, co-pays, communication, and data usage
Goals	Comments about the perceptions or awareness of goals of [Retroactive Eligibility / Cost Sharing / NEMT /HBI] program for participants, providers, insurers, Medicaid population, and the state.
Effectiveness	Respondent perceptions of how effective or ineffective the policy at achieving or progressing towards goals
Spillover effects	Comments about unintended consequences or impacts of the program outside of its intended impact (creating burden in other settings or untargeted populations (e.g., provider administrative burden))
Supplementary efforts	Comments about tangential efforts that support the policy's implementation, awareness or participation, completed by stakeholders not directly responsible (via contractual obligations) for outcomes
Member experience	Comments speculating about member experiences interacting with the program, including receiving and understanding information, life circumstances, health needs, ability to comply, preparedness for co-pays
Communication about policy	Comments about communication from the state, MCOs, providers, others about the components of the policy /program, including frequency, methods, reminders, etc.
Disparities	Respondent comments about differences in awareness, (dis)enrollment, compliance rates of across different populations within IHAWP (e.g., rurality, age, race, income, gender)
Procedural	Comments about the details of the general processes, including data collection, compliance, communication, implementation, enforcement, enrollment
Coordination across stakeholders	Comments about the intersections of MCO and provider efforts similar to state efforts and how they align (or are independent from) the state programs/ policies
Enforcement	Comments about the co-pay / premium billing and collection, disenrollment, member notification, and roles involved
HBI HRAs	Comments about the Health Risk Assessments administered by MCOs which fulfill the state HBI requirements and / or qualify members for MCO-specific incentives
Content	Comments related to the content of HRAs, including topics covered, development and selection, and purpose of inclusion
Data export and sharing	Comments related to how HRA data is shared and distributed, with which stakeholders, and at what level of specificity (e.g., by subpopulation, individual cases, overall population)
Data use	Comments about how HRA data is used (e.g., to inform patient care, compliance with federal and state programs, present aggregate data at meetings, inform strategic direction and programming) and general findings

Appendix D: Hypotheses by Area of Emphasis

NEMT Hypotheses and Research Questions

Hypothesis 1: Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.

Research Question 1.1: Are adults in the IHAWP less likely to report barriers to care due to transportation than other adults in Medicaid?

Research Question 1.2: Are adults in the IHAWP less likely to report transportation-related barriers to complete HBI requirements than other adults in Medicaid who report awareness of the NEMT benefit?

Research Question 1.3: Are adults in the IHAWP less likely to report barriers to care for chronic condition management due to transportation than other adults in Medicaid who report awareness of the NEMT benefit?

Research Question 1.4: Are adults in the IHAWP less likely to report unmet need for transportation to health care visits than other adults in Medicaid who report awareness of the NEMT benefit?

Research Question 1.5: Are adults in the IHAWP less likely to report worry about the ability to pay for cost of transportation than other adults in Medicaid who report awareness of the NEMT benefit?

Hypothesis 2: Wellness Plan members without a non-emergency transportation benefit will have equal or lower rates of missed appointments due to access to transportation.

Research Question 2.1: Are adults in the IHAWP less likely to report transportation-related missed appointments than other adults in Medicaid who receive the NEMT benefit?

Hypothesis 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.

Research Question 3.1: Do adults in the IHAWP less frequently report that their health care plan provides non-emergency transportation than other adults in Medicaid who receive the NEMT benefit?

Hypothesis 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.

Research Question 4.1: Do adults in the IHAWP who live in rural areas report similar experiences with health-care related transportation as other adults in Medicaid who receive the NEMT benefit?

Research Question 4.2: Do adults in the IHAWP who have limitations to activities of daily living report similar experiences with health-care related transportation as other adults in Medicaid who receive the NEMT benefit?

HBI Hypotheses and Research Questions

Hypothesis 1: The proportion of members who complete a wellness exam, health risk assessment, or both will vary.

Research Question 1.1: What proportion of members complete a wellness exam in a given year?

Research Question 1.2: What proportion of members complete an HRA in a given year?

Research Question 1.3: What proportion of members complete both required activities in a given year?

Hypothesis 2: The proportion of members completing a wellness exam, health risk assessment, or both will change over time and by income level.

Research Question 2.1: Has the proportion of members completing a wellness exam decreased among lower-income members and increased among higher-income members?

Research Question 2.2: Has the proportion of members completing an HRA decreased among lower-income members and increased among higher-income members?

Research Question 2.3: Has the proportion of members completing both required activities decreased among lower-income members and increased among higher-income members?

Hypothesis 3: Member characteristics are associated with the likelihood of completing both required HBI activities.

Research Question 3.1: Are older, non-Hispanic white females living in metropolitan counties more likely to complete both required activities?

Research Question 3.2: Are members assigned to some MCOs more likely than members assigned to other MCOs to complete both required activities?

Research Question 3.3: Is the length of time in the program positively associated with the likelihood of completing both required activities?

Research Question 3.4: Are members with more negative social determinants of health (SDH) less likely to complete both required activities?

Research Question 3.5: Is the highest income group most likely to complete both required activities?

Hypothesis 4: Completing HBI requirements is associated with a member's use of the emergency department (ED).

Research Question 4.1: Are members who complete the HBI requirements equally likely to have an ED visit?

Research Question 4.2: Do members who complete the HBI requirements have fewer total ED visits annually?

Research Question 4.3: Are members who complete the HBI requirements less likely to have a non-emergent ED visit?

Research Question 4.4: Do members who complete the HBI requirements have fewer total non-emergent ED visits annually?

Research Question 4.5: Are members who complete the HBI requirements less likely to have a 3-day, 7-day, or 30-day return ED visit?

Research Question 4.6: Do members who complete the HBI requirements have fewer total 3-day, 7-day, or 30-day return ED visits annually?

Hypothesis 5: Completing HBI requirements is associated with a member's use of hospital observation stays.

Research Question 5.1: Are members who complete the HBI requirements equally likely to have a hospital observation stay?

Research Question 5.2: Do members who complete the HBI requirements have fewer total hospital observation stays annually?

Hypothesis 6: Completing HBI requirements is associated with a member's use of inpatient hospital care.

Research Question 6.1: Are members who complete the HBI requirements equally likely to be hospitalized?

Research Question 6.2: Do members who complete the HBI requirements have fewer total hospitalizations annually?

Research Question 6.3: Are members who complete the HBI requirements less likely to have a potentially preventable hospitalization?

Research Question 6.4: Do members who complete the HBI requirements have fewer total potentially preventable hospitalizations annually?

Research Question 6.5: Are members who complete the HBI requirements less likely to have a 30-day all-cause readmission?

Research Question 6.6: Do members who complete the HBI requirements have fewer total 30-day all-cause readmissions annually?

Hypothesis 7: Completing HBI requirements is associated with shifts in patterns of member's health care utilization.

Research Question 7.1: Do members who complete the HBI requirements have fewer potentially preventable hospitalizations as a proportion of total hospitalizations?

Research Question 7.2: Do members who complete the HBI requirements have fewer non-emergent ED visits as a proportion of total ED visits?

Research Question 7.3: Do members who complete the HBI requirements have more primary care visits as a proportion of total outpatient visits?

Hypothesis 8: Completing HBI requirements is associated with a member's health care expenditures.

Research Question 8.1: Do members who complete the HBI requirements have lower spending in all categories?

Hypothesis 9: Disparities exist in the relationships between HBI completion and outcomes.

Research Question 9.1: 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?

Hypothesis 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.

Research Question 10.1: What is the level of awareness about the HBI program among members?

Research Question 10.2: How long are members enrolled in the program?

Research Question 10.3: Is there a relationship between length of enrollment and awareness of the HBI program?

Hypothesis 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

Research Question 11.1: What specific knowledge about the HBI program do members report?

Research Question 11.2: Do members understand incentive/disincentive part of the HBI program?

Research Question 11.3: Do members know they need to pay a premium monthly?

Research Question 11.4: Do members know about the hardship waiver?

Research Question 11.5: How long have members been enrolled?

Hypothesis 12: Those who are aware of the HBI program are more likely to complete the behaviors (HRA and well exam) compared to those who are not aware.

Research Question 12.1: What is the level of awareness of the HBI program?

Research Question 12.2: What is the level of completion of the HRA and well exam?

Hypothesis 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.

Research Question 13.1: What is the level of knowledge about the HBI program?

Research Question 13.2: What is the level of completion of the HRA and well exam?

Hypothesis 14: Member socio-demographic characteristics and perceptions/attitudes are associated with awareness of the HBI program.

Research Question 14.1: What is the level awareness of the HBI program?

Research Question 14.2: What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members?

Research Question 14.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?

Hypothesis 15: Member socio-demographic characteristics and perceptions/attitudes are associated with knowledge of the HBI program.

Research Question 15.1: What is the level knowledge of the HBI program?

Research Question 15.2: What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members?

Research Question 15.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?

Hypothesis 16: Member socio-demographic characteristics and perceptions/attitudes are associated with completion of the HRA and well exam.

Research Question 16.1: What is the level of completion of the HRA and well exam?

Research Question 16.2: What are the socio-demographic characteristics (age, gender, income, education, employment, race, and ethnicity) of members?

Research Question 16.3: What are the perceptions/attitudes (self-efficacy, response efficacy, perceived susceptibility, perceived severity, and perceived benefit) of members?

Hypothesis 17: Members are most likely to hear about the HBI program from their MCO.

Research Question 17.1: Where are members learning about the HBI program and HBI program components?

Hypothesis 18: Members report challenges in using hardship waiver.

Research Question 18.1: What are the perceptions of the ease of use of the hardship waiver?

Research Question 18.2: What are the challenges members report in using the hardship waiver?

Hypothesis 19: Members who do not complete the HRA and wellness exam, report barriers to completing the behaviors.

Research Question 19.1: What are the barriers to completing the HRA and wellness exam as reported by the members?

Hypothesis 20: Disenrolled members report no knowledge of the HBI program.

Research Question 20.1: What is the level of HBI program knowledge among disenrolled members?

Hypothesis 21: Disenrolled members describe confusion around the disenrollment process.

Research Question 21.1: How do disenrolled members describe the process of learning about their disenrollment?

Hypothesis 22: Disenrolled members report consequences to their disenrollment.

Research Question 22.1: What happens after members are disenrolled for non-payment?

Research Question 22.2: Will disenrolled members be able to reenroll to health insurance coverage?

Research Question 22.3: Do the consequences change over time?

Retroactive Eligibility Hypotheses and Research Questions

Hypothesis 1: Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.

Primary Research Question 1.1: Are people subject to the waiver of retroactive eligibility more likely to enroll in Medicaid relative to members in the same programs prior to the waiver?

Subsidiary Research Question 1.1a: Are people subject to the waiver of retroactive eligibility more likely to enroll while still healthy relative to members in the same programs prior to the waiver?

Subsidiary Research Question 1.1b: Are people subject to the waiver of retroactive eligibility more likely to enroll earlier?

Primary Research Question 1.2: Do people subject to the waiver of retroactive eligibility have increased enrollment continuity relative to members in the same programs prior to the waiver?

Subsidiary Research Question 1.2a: Do people subject to the waiver of retroactive eligibility understand that they will not be covered during enrollment gaps?

Subsidiary Research Question 1.2b: What are the barriers to timely renewal for those subject to the waiver of retroactive eligibility?

Subsidiary Research Question 1.2c: Among members subject to the retroactive eligibility waiver, is timely renewal more likely by those who might be expected to value coverage highly, relative to those who might value coverage less?

Subsidiary Research Question 1.2d: Are people subject to the waiver of retroactive eligibility more likely to remain continuously enrolled relative to members in the same programs prior to the waiver?

Subsidiary Research Question 1.2e: Are people subject to the waiver of retroactive eligibility more likely to re-enroll relative to members in the same programs prior to the waiver?

Hypothesis 2: Eliminating retroactive eligibility will not increase negative financial impacts on members.

Primary Research Question 2.1: Are there any negative financial impacts on consumers because of the waiver of retroactive eligibility relative to members in the same programs prior to the waiver?

Subsidiary Research Question 2.1a: Do beneficiaries subject to the waiver of retroactive eligibility experience greater 'medical debt' relative to members in the same programs prior to the waiver?

Subsidiary Research Question 2.1b: Do hospitals experience higher rates of uncompensated care after the enactment of the waiver of retroactive eligibility?

Hypothesis 3: Eliminating retroactive eligibility will improve member health.

Primary Research Question 3.1: Do people who are subject to waiver of retroactive eligibility have better health outcomes?

Hypothesis 4: Eliminating retroactive eligibility will reduce the annual Medicaid services budget.

Primary Research Question 4.1: What are the effects on the Medicaid services budget?

Hypothesis 5: Providers will increase initiation of Medicaid applications for eligible patients/clients

Primary Research Question 5.1: Have health care providers increased the initiation of Medicaid applications for eligible patients/clients?

Cost Sharing Hypotheses and Research Questions

Hypothesis 1: Members understand the $8 copayment for non-emergent use of the ER.

Research question 1: Do members understand the $8 copayment for non-emergent use of the ER?

Hypothesis 2: Cost sharing improves member understanding of appropriate ER use.

Research Question 2.1: Do members subject to an $8 copayment understand appropriate use of the ER better than members who are not subject to the copay?

Research Question 2.2: Do members subject to an $8 copayment understand cost of the ER better than members who are not subject to the copay?

Research Question 2.3: Are members subject to an $8 copayment for non-emergent use of the ER less likely to use the ER for non-emergent care?

Research Question 2.4: Are members subject to an $8 copayment for non-emergent use of the ER more likely to use the primary care providers for non-emergent care?

Hypothesis 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.

Research Question 3.1: Are members who are subject to the $8 copayment for non-emergent ER use more likely to have a regular source of care than those not subject to the copayment?

Research Question 3.2: Are members who are subject to the $8 copayment for non-emergent ER use more likely to receive preventive care and chronic care monitoring than those not subject to the copayment?

Hypothesis 4: Cost sharing improves long-term health care outcomes.

Research Question 4.1: Do members who are subject to the $8 copayment for non-emergent ER use have more favorable long-term health care outcomes?

Appendix E: Supplemental Information

The following appendix contains information that is not specific to the IHAWP program, but rather to all Medicaid programs in general.

- IHAWP overall has increased capacity of providers to receive reimbursement for more patients and shift resources from providing care for uninsured

    - *"It's [IWP] improved how we are able to leverage and use our federal funds to increase the population we serve, or to expand the services that we offer our current population."* – Provider association representative

    - *"Just having the IHAWP program on top of traditional Medicaid was a big win for our provider type. It went from us having to cover a number of folks, so we can't federally turn anybody away for their inability to pay…So, it created space and room for us to grow to serve more people, to get paid for a population we were already seeing, who was uninsured or underinsured... So, I think, for us, we truly do think that the expansion program was a big win for the state and for our population."* – Provider association representative

- **Support the workforce by raising reimbursement rates and leveraging technology to mitigate fatigue**

    "Our top, and really only priority this legislative session, is to get a significant increase in the rates that are paid to providers so that we can pass those along to the workforce…we're also looking at real systems change, in utilization of enhanced technology to supplement the workforce remote monitoring when appropriate, the implementation of smart homes. You know if someone leaves the oven on too long, that it creates a safety hazard. If someone doesn't leave the bed, or doesn't move in the bathroom for a period of time, we don't want to be in the bathroom watching if the person is independent, but certainly can intervene if there has been no movement. Some of those technologies, we're looking at what other providers have done in different states to try to relieve the burden on workforce, specifically by supplementing with technology. It's a long term solution for an impending crisis."

Opportunities for Improvement

- Leveraging technology to incorporate innovative approaches like telehealth and smart homes

- Need to streamline categorical eligibility member management within IHAWP and facilitate transition between *medically exempt* and *general population* statuses through automated systems

- Need for consistent leadership with inclination to invest in and develop more involved and meaningful oversight of Managed Care Organizations (MCOs)

- Lack of stability amongst managed care providers disrupts progress towards statewide health reform goals like value-based payment models

- Increase preventative care access in rural areas

- Support the workforce by raising reimbursement rates and leveraging technology to mitigate fatigue

- **Need for consistent leadership with inclination to invest in and develop more involved and meaningful oversight of MCOs**

"The legislature, with the Republican majority, has been hands off. They are required to have two oversight committee meetings a year, and they do it at the end of December, one in the morning, one in the afternoon. They have people speak for a couple of hours and call it a day. There is no oversight from the legislative perspective. Any attempts to try to increase the level of accountability have largely not been successful by the legislature. The department has said it's a contracting issue. Again, we're trying to catch up to decisions that were made more than six years ago. The department has not had the resources to hire the consultants or staff that have expertise in simply contracting and oversight. These large fortune 500 companies come with their myriad of attorneys who, that's what they do for a living. Even from the very beginning, the contracting is skewed toward the benefit of the MCOs. I think with regard to administrative leadership, under the direction of Director Garcia, and to now Liz Matney is the Medicaid director, there is a very strong desire to right size if you will. But again, we're still trying to catch up from decisions that were made long before they came into their positions." – Provider association representative*

"With all of the talk of the move to managed care as a way to improve health outcomes and save money, it has done neither. I think people have gone backwards. Part of that is, I think, due in large part to the state's lack of oversight from the very beginning, and we're still trying to catch up." – Provider association representative*

"It's gotten better over the course of the last six years, but I would not say it's in a place that it is better than prior to being moved to managed care." – Provider association representative*

- **Lack of continuity amongst managed care providers disrupts progress towards statewide health reform goals like value-based payment models**

"[There has been] significant change over time. We've had multiple MCOs come in. There's this fruit basket upset that impacts individual Medicaid members and providers having to learn new systems. Frankly, we have not moved to a managed care model where we're focused on value-based outcomes when it comes to long term service and support. We're still under fee for service. We're just administered by multiple organizations, which costs more money, takes more time, is completely inefficient, and it's not leading to better outcomes." – Provider association representative*

- **Preventative care access in rural areas**

"One of the other challenges we always have to navigate is access, especially in more of our rural communities where the primary place to receive healthcare is the local community access hospital. And sometimes we see inappropriate utilization there. Sometimes we see extremely appropriate utilization as well." – MCO representative*

- **Continuation of telehealth parity post pandemic**

"Perhaps the one thing I would add which is still maybe a little bit across the board, Medicaid in Iowa, would be continued parity on telehealth, particularly related to audio-only and expansion of telehealth into some areas related to dental and medical, that through more developments in the pandemic, we have found are actually viable areas to offer telehealth." – Provider association representative*

- **Support the workforce by raising reimbursement rates and leveraging technology to mitigate fatigue**

"It can get frustrating, especially when you're burnt out from a pandemic…We keep telling them, 'You don't want expansion to go away. You're not going to get the MCOs to go away. We've got to figure out how to make this work.'" – Provider association representative

Communication Across Stakeholders

Interviewees commented on the state of communication between the state's main Medicaid stakeholders, describing the purpose of communication, and noting positive and negative experiences. A representative from Iowa Medicaid illustrated the inclusive approach to stakeholder engagement, saying, *"I know that a lot of our meetings that we have that include MCOs, we also include some providers and stakeholders. Some of our meetings do include some members. So, there's a variety of stakeholders, not just companies."*

Stakeholders described the various reasons for communicating and collaborating across the state Medicaid agency, provider associations and MCOs, noting involvement in state hiring, policy details, problem solving, shared metrics, responding to concerns, and strategic direction.

"We've been involved in some of the big policy decisions, we've been involved in some of the interview and process decisions related to hiring of some of the bigger folks lately, and we've had some involvement in this latest [MCO] RFP as well. I would say it's a growing area for them [Iowa Medicaid]. I think they've tweaked their list as we've grown as an organization, and they've seen what we have provided to the state, particularly in COVID. I think they have grown in how and when they reach out to us. I think there's still ways they could improve and making sure that they get the view of all providers. I think some of it too, quite frankly, is just resources, time, and staff, which we understand." – Provider association representative

"[Interactions with MCOs are] related to value-based programs, we annually contract with them [MCOs] and then get periodic monthly or quarterly updates on claims, data, and whether we're meeting the metrics that we both agreed to work on… it's a three-part contract that looks at reducing overall cost, meeting certain quality metrics for the year, and then also there's some data and report-sharing components as well." – Provider association representative

"It's not as in-depth conversations, but we definitely know who to contact at both of the payers, and often have conversations or they reach out to us to get connected maybe with someone, or we'll help somebody get connected to them to result certain issues that they may be having at the micro level, between patients and payers." - Provider association representative

"We meet routinely to talk about policy and policy deliberation, so I'd say that we spend a lot of time responding or addressing the concerns of legislators, government leaders at the state, as well as member stakeholders and advocates." – MCO representative

"They [MCOs] also participate in our weekly phone call, which is a Zoom, for all of our providers. I have a standing monthly meeting with leadership of each of the MCOs. Of course, I'm in regular contact with them throughout the month as issues come up that we need to address. I would have to say they have been very responsive when we've brought issues to them." - Provider association representative

"We have a once-a-week meeting with all of our providers that the Medicaid director attends. It is mostly an update of what's happening at the federal and state level. We also have a once-a-week meeting for executive directors of the association with Liz, Director Matney. That is more consultative, developing

solutions. We're really focused on the workforce issue, but it obviously goes into a variety of different details for policy related issues. I talk regularly to folks on their policy team on rules, regulations, innovative new things coming up, ideas that we should be looking at, and always they are available for addressing problems that come to me through providers." - Provider association representative

Yeah, absolutely, extremely collaborative. Policy front, program front, opportunities, broader community engagement, very, very actively engaged with them [Iowa Medicaid]. – MCO representative

Positive Experiences

Generally, interviewees expressed positive, engaged, and collaborative relationships across the state Medicaid agency (Iowa Medicaid), provider associations, and the state's MCOs (Amerigroup and Iowa Total Care). Stakeholders expressed satisfaction with amount of communication across stakeholders, utilizing various methods to connect, including email, phone, in-person, and videoconference. Interviewees from MCOs and Iowa Medicaid reported routine communication across these two groups, describing the frequency as "daily," "all day, every day," and "constant." Provider association representatives both mentioned monthly meetings with the state Medicaid Director, along with intermittent ad hoc communication.

A provider association representative noted less frequent communication with MCOs (compared to Iowa Medicaid and MCO interaction), saying, *"we have monthly meetings, at least with both the MCOs, sometimes more frequently, depending on the need."*

A representative from a provider association expressed satisfaction with engagement with Iowa Medicaid, saying, *"under the current leadership, we are delighted with the level of communication that we have had with Director Matney and leadership with Iowa Medicaid."*

Areas for Improvement

Representatives from both MCOs described a desire for communication that was more mutually collaborative with Iowa Medicaid, as illustrated in the following comments:

"I think the interaction is very good and very collegial. I wish it could be more collaborative. The state has an oversight responsibility for our work that I think they take very seriously and formalize as much of the interaction, and I do not fault them for that. I think it's what they have to do because they are our client, and we serve as well as the members, but if I could have my druthers, it'd be a little more partnership and problem solving, but I respect the distance because of the need for oversight of our work." – MCO representative

"The total health plan, the total benefit run by Iowa Medicated Enterprise is pretty complex. A lot of decisions get made every day, and there are a lot of opportunities to share knowledge that because of the oversight role, I think it's a little harder sometimes for it to be bidirectional." – MCO representative

Provider association representatives described inconsistent collaborative involvement with the MCOs and, at times, Iowa Medicaid, as portrayed in the following statements:

"Sometimes we get caught off guard by an informational letter, and then there's other times, they [Iowa Medicaid] are really good about ensuring that they get stakeholder input and involve, particularly, our CEO in different decisions." – Provider association representative

"I think the MCOs, because they're both the ones that are currently in Iowa, are both owned by larger national entities, they may be willing to make some of those changes and fix things at the state level, and the state may be willing to too, but then escalating that up to the MCO level where the ownership is…It

sometimes gets lost in translation or the staff isn't there to do it, just multiple things that can cause it to be a bigger hiccup. So, just some learning curves for the health centers on billings, some learning curves for the MCOs, still on how they respond to timely filed claims. And then we've just stepped up a lot as an organization and had to provide a lot more escalation and assistance on some of these items just to keep things moving forward. We've really had to put in a lot of extra work to make some of the bumps smooth over." – Provider association representative

In cases in which a collaborative opportunity was missed and impacts on providers need to be remedied, a provider association representative reported responsive, saying, *"We've been caught off guard, but then when we've shared questions about it or concerns about how it worked, then we've been involved in reworking or reconsiderations of those policy decisions."* – Provider association representative

Interview Comments Supplemental Information

The main stakeholders in the state will be shifting with the anticipated addition of another MCO. In conjunction with the expiration of Amerigroup's contract, slated to end in July 2023, the state is in the process of issuing an additional MCO RFP, with contract award anticipated in fall 2022 (July 2023 operational start).(1)

Appropriations were increased and passed in the Iowa Legislature, resulting in a total caption rate increase of $153 million towards MCO contracts.(1)

Iowa Total Care is subject to a $44 million withhold and underwent an independent review which concluded in March 2021. The sanction and review were prompted by unaddressed outstanding claims payments to providers. The withheld funds were released incrementally, with Iowa Total Care eventually receiving $43.5 million as of April 2021.

COVID Pandemic

Beginning on March 20, 2020, the Department of Human services issued a list of flexibilities in response to the COVID-19 pandemic, which allowed additional services, and suspended disenrollment and cost sharing.(6) In addition, the Department developed a variety of resources to disseminate details of COVID flexibilities, including a COVID-19 Medicaid Provider Toolkit. (7)

Since March 2020, Iowa has maintained enrollment for Medicaid members, pursuant to the Maintenance of Effort (MOE) requirement to receive enhanced Federal Medical Assistance Percentage (FMAP) funding during the pandemic.

Post Public Health Emergency Planning

As early as an October 8, 2020 Medical Assistance Advisory Council (MAAC) meeting, the Medicaid Director announced that "the Department has begun working internally and with the Managed Care Organizations (MCOs) and other stakeholders to discuss how to wind down waivers and flexibilities implemented during the PHE." (8) Following these initial plans to discontinue pandemic-related flexibilities, the PHE was extended January 8, 2021 (9) and again on April 21, 2021. (10)

In January 2021, the Legislative Services Agency provided an update on Medicaid enrollment and Federal Medical Assistance Percentage (FMAP) requirements during the public health emergency, attributing increased enrollment to suspending disenrollments, stating:

Before COVID-19, Medicaid enrollment growth was relatively flat. The Medicaid Program has seen a large spike in enrollment over the past six months as a result of suspending disenrollment. The

maintenance-of-effort requirement for receiving a 6.2% FMAP increase does not allow the State to disenroll anyone while the federal public health emergency is in effect.(11)

Prior to Governor Kim Reynolds' declaration to end the Public Health Emergency in Iowa (effective February 15, 2022) (11) the state's Health Policy Oversight Committee convened on December 20, 2021. The Department shared figures on enrollment trends and cost projections before and after the public health emergency (Figure 6). This meeting also included detailed plans to recall flexibilities related to the PHE. (1)

Figure 6. Iowa Department of Human Services Budget Presentation to Health Policy Oversight Committee (12)

Pre-Public Health Emergency Enrollment -- February 2020			
Eligibility Type	Feb-20 MCO Membership	Per Member Per Month Cost	Total Monthly Cost
Children	241,296	225.20	54,339,525
Parents and Caretakers	64,073	454.95	29,149,719
Iowa Health and Wellness Plan	170,669	557.88	95,213,494
Elderly and Disabled -- Non-LTSS	65,471	994.21	65,091,598
Elderly and Disabled -- LTSS Institutional	14,768	4,007.18	59,178,024
Elderly and Disabled -- LTSS Home and Community	24,934	5,076.37	126,574,210
Total	**581,211**	**739.05**	**429,546,569**

Public Health Emergency Enrollment -- October 2021			
Eligibility Type	Oct-21 MCO Membership	Per Member Per Month Cost	Total Monthly Cost
Children	282,911	221.70	62,722,140
Parents and Caretakers	85,126	455.41	38,767,213
Iowa Health and Wellness Plan	220,702	550.23	121,437,123
Elderly and Disabled -- Non-LTSS	73,432	932.42	68,469,603
Elderly and Disabled -- LTSS Institutional	13,150	4,034.45	53,053,043
Elderly and Disabled -- LTSS Home and Community	24,586	5,089.85	125,139,063
Total	**699,907**	**670.93**	**469,588,183**

Percent Change			
Eligibility Type	MCO Membership	Per Member Per Month Cost	Total Monthly Cost
Children	17.2%	-1.6%	15.4%
Parents and Caretakers	32.9%	0.1%	33.0%
Iowa Health and Wellness Plan	29.3%	-1.4%	27.5%
Elderly and Disabled -- Non-LTSS	12.2%	-6.2%	5.2%
Elderly and Disabled -- LTSS Institutional	-11.0%	0.7%	-10.4%
Elderly and Disabled -- LTSS Home and Community	-1.4%	0.3%	-1.1%
Total	**20.4%**	**-9.2%**	**9.3%**

In Informational Letter 2315, released February 20, 2022, the Department of Human Services released an initial response to Medicaid Providers, iterating "The end of the state-declared PHE does NOT impact Medicaid flexibilities currently in place."(13)

Regarding communication about the end of COVID flexibilities and communication with members, one MCO representative said, *"I guess I would assume that communication may come from the state if they're going to do that, just because they're the ones charging the premium. And I would think that would be probably more effective for members, if they see something in the mail from the state, as opposed to us, I think sometimes it's got a little bit of a higher priority for members. Or I've heard that from members when they've missed our mailings or haven't paid attention to them so."* In response to the same question, a representative from Iowa Medicaid speculated a role for MCOs in the communication to members following the PHE, saying *"I would assume they would. And the MCOs also do a lot of that type of stuff."*

> *"Yeah, I think there's going to be a lot of education done around that. I think people aren't going to be aware when they enroll up. I think there's going to be a big lift for our enrollment folks to ensure that they know when people need to be re-enrolled. And there's going to be a big pressure to do those eligibility checks to get people re-enrolled again. And then with the PHE, a lot of that work's just been put on hold when it's been waived too. So, I think the state will need to do some education, MCOs will need to do*

some education, we'll need to do some education, providers will need do some education." – Provider association representative

A provider association representative talked about the potential impact of a vaccine mandate on the workforce, describing a precarious situation, saying, *"they [Medicaid members] are losing access to service because the staffing crisis, and that the vaccine mandate will exacerbate that existing crisis."*

Regarding potential disruption to members and providers following the end of the Public Health Emergency (PHE), one MCO representative said, *"It's a good example of why the pandemic waivers are written to allow 60 days' notice out to providers and payers about the end of any flexibility, which will be done in a staged way."*

Representatives from MCOs talked about the post-PHE policy changes and dissemination of information, saying, *"we'd probably follow Iowa Medicaid's lead on that in terms of kind of the, what they would call the unwinding of the public health emergency. I think those are some of the details they're probably still working out…There would be public notices by Iowa Medicaid that, those current waivers that they have with CMS would be lifted, but how exactly that would happen mechanically I'm not sure that we know yet."* And *"the state will be communicating all of that to people saying, 'Okay, now you will start dropping off,' or, 'You're going to stay on, but you're going to have to start paying the copay.' They've got a lot that they'll be doing."*

NEMT and Transportation Context

- Interviewees discussed transportation options for IHAWP members without the NEMT benefit, suggesting utilizing public transportation, social supports (friends and family), and community resources, such as churches.

Activity in State

Discussions about transportation, hardship, and Non-Emergency Medical Transportation (NEMT) providers took place during the reporting period. In Amerigroup's assessment of the state's social drivers of health, it was reported that transportation support is the third most common need amongst members. (14) In addition, transportation was identified as a consistent theme emerging from Member and Provider Town Halls, which prompted the formation of a dedicated working group. (1)

NEMT vendor, Access2Care

In regard to the state's contracted NEMT vendor Access2Care, several concerns were brought up in various public forums, including Medicaid Town Halls and MAAC meetings. Issues encountered and reported included the following:

- Lack of web-accessible interface for members to schedule appointments(15)

- Limitations on parental accompaniment to child's appointments (only one parent allowed)(15)

- Reports of increasing issues – "On the grievance report, most grievances continue to be on the topic of transportation. As enrollments increased, so has the number of appeals." (16)

- Vehicles available not adequate to meet demand (15)

- Long wait times – "can take a whole day just to go to the doctor with waiting time before and after pickups"(15)

- Miscommunication from MCOs about benefit eligibility(15)

Since 1966, states have been required to provide Medicaid beneficiaries with non-emergency medical transportation (NEMT). (17, 18) Almost all public and commercial health insurance plans provide coverage for transportation to emergency medical care, but Medicaid law is rare in that it ensures transportation coverage for nonemergency, but medically necessary, care (19) NEMT is a mandatory Medicaid benefit, but states can limit its availability through federal waivers. (18) Health care transportation includes any transportation to medical facilities that is classified as non-emergency in (e.g., to medical appointments, to an urgent care facility, or being discharged from the hospital. (20) Medicaid non-emergency medical transportation (NEMT) is a Medicaid benefit the facilitates access to and from medical services for beneficiaries who have no means of transportation, or who need accommodations for physical or intellectual disabilities. (20)

Goals and intent

Approximately 3.6 million Medicaid beneficiaries "miss or delay care" annually due to transportation problems. (21) NEMT provides Medicaid beneficiaries who lack the means to travel to and from medical appointments with the most appropriate and least costly form of transportation, which may involve the use of livery vehicles, vans, or public transit. (21) NEMT varies by state, as does the scope of its benefit. NEMT generally covers a broad range of transportation services, including trips in taxis, buses, vans, ambulances, public transportation, and personal vehicles belonging to Medicaid beneficiaries and their families or friends. (22) In 2016, NEMT was most frequently used to access behavior health services (including mental health and substance abuse treatment, dialysis, preventive services (including doctor visits, specialist visits, physical therapy/rehabilitation, and adult day health care services. (21)

Impact on providers and cost

Approximately 3.2 million Medicaid beneficiaries used NEMT in 2018. (22) In the fiscal year 2018, there were over 60 million NEMT ride-days. State and federal spending on NEMT was $2.6 billion (excluding managed care payments to providers), with an average of about $40 per full-year-equivalent enrollee. (22) Comprehensive data about Medicaid NEMT does not exist because states are not required to separately report on this item, but the Transit Cooperative Research Program estimates NEMT spending at $3 billion annually, which is less than 1% of total Medicaid expenditures (20) NEMT is beneficial for care providers as well as because NEMT increases options for reliable patient transportation. This means that care providers see a reduction of no-shows and late arrivals, increased treatment adherence, and greater bed turnover as patients are discharged more swiftly. (20) Additionally, insurers benefit from NEMT because adherence to preventive care and maintenance of chronic conditions can reduce unnecessary emergency department visits, thus saving money. (20) Although it is difficult to isolate the impact of transportation on health outcomes, a study conducted by Florida State University concluded that if only 1% of the medical trips funded resulted in the avoidance of an emergency department hospital visit, the payback to the State would be 1108%, or about $11.08 for each dollar the State invested in its medical transportation program. (18)

Other state examples

Most states require that beneficiaries verify that they need transportation for covered medical services and have no other way to get to their appointment. Other states require a health care provider to document that the beneficiary needs NEMT. (22) NEMT program performance varies across and within states. Beneficiaries report concerns such as late pickups, ill-equipped vehicles, and long call center

wait times. (22) The majority of states deliver NEMT through NEMT brokers or managed care organizations (MCOs). In most of these states, the broker or MCO receives a per capita payment to manage the NEMT benefit. A few states directly fund government entities such as departments of transportation to provide NEMT while others deliver NEMT on a fee-for-service basis through local service providers. (20) Indiana, Iowa, Kentucky, and Massachusetts have waiver applications that would curtail NEMT to some expansion population beneficiaries. (18)

Unintended consequences

NEMT is at high risk for fraud and abuse, according to a 2016 Government Accountability Office study. (21) After this report was published, CMS issued a NEMT Toolkit designed to give states and NEMT providers a primer on providing NEMT. (21) Although federal policy encourages coordination across federally assisted transportation programs, NEMT is not well coordinated with other programs in most states. (22) Additionally, inappropriate or ill-equipped vehicles are a common reason for beneficiary complaints as well as reliability of provider/driver, safety and accessibility, and unanswered and unresolved complaints submitted through formal channels. (22)

Best practices

Formal partnerships between ride sourcing companies, health care providers, insurers, and transit agencies have made ridesharing options available for patients. Benefits of ridesharing options include the on-demand nature of rides, booking flexibility, and integration of ride requests and payment options via electronic medical records. (20) Administration should abandon plans to make NEMT an optional benefit. (21) State transparency of NEMT data should be enhanced so the efficiency of transportation services improves. NEMT data should be easily linkable with medical claims data so that administrators and researchers can better study their impact on health care outcomes. (17) Researchers suggest robust options to improve and innovate NEMT to enhance the experience for patients and providers.

COVID-19

The COVID-19 pandemic reduced NEMT use. The use of telehealth services may reduce the need for NEMT services, but the extent to which this occurs will depend on the design of Medicaid telehealth policies post-pandemic and acceptance of telehealth by beneficiaries and providers. (22)

Status in Iowa

Iowa, Indiana, Kentucky, Utah and Georgia were permitted to remove NEMT for their Medicaid Expansion and Non-Expansion populations through the approval of 1115 waivers by CMS. (17) The Iowa Health and Wellness Plan demonstration, originally approved in 2013 and now authorized through 2024, excludes NEMT for the new adult group, except for those who have been determined medically exempt or are eligible for EPSDT services (i.e., beneficiaries age 19 and 20). (22)

Supplemental information

> Several studies have examined the effect of NEMT on health outcomes and cost savings. For example, a 2001 study conducted by the University of Florida estimated that if at least 1 percent of NEMT trips resulted in avoidance of an emergency room visit, the state would save $11.08 for each dollar it invested in the program (Cronin et al., 2008). Additionally, a 2018 study of actual NEMT users found that when used as part of a care management strategy for people with certain chronic diseases (i.e., dialysis for kidney diseases and wound care for diabetic wounds), NEMT produces substantial return on investment (Adelberg et al., 2018). (22)

The Return on Investment (ROI) of NEMT to attend regular dialysis treatments for treating kidney disease per 10,000 members per month is $34,229,448. The ROI of NEMT to attend diabetic wound care treatments per 10,000 members per month is $7,920,635).(23)

Going further, President Trump's 2019 Department of Health and Human Services (DHHS) budget proposal included regulation that would make it easier for states to curtail NEMT without requiring a waiver. While challenging to predict how each state's Medicaid program will ultimately proceed, these policy shifts create uncertainty for the future of NEMT. In particular, states with political pressure to address short-term budgetary shortfalls may move to contain the rising costs of Medicaid by shifting dollars away from NEMT. This move may prove harmful.(17)

Healthy Behaviors Context

Definition of Policy

Medicaid programs across the country are encouraging enrollees to engage in healthy behaviors such as attending primary care appointments, completing a health assessment, filling prescriptions, maintaining a healthy diet, increasing physical activity, or quitting smoking.(24) There is growing interest in implementing healthy behavior programs and incentives due to the higher rate of unhealthy behaviors, such as smoking, among Medicaid beneficiaries versus the privately insured population. (25) State Medicaid programs and Medicaid managed care organizations (MCOs) typically use financial incentives such as gift cards, prizes, reduced premiums or copays, or penalties to promote said healthy behaviors. (26) As Medicaid authority has evolved over time, states now generally use one of three authorities to implement healthy behavior programs: 1115 waivers, alternative benefit plans, and grant funding. Additionally, the Affordable Care Act (ACA) created new opportunities for states to implement healthy behavior programs and in 2011, the Centers for Medicare and Medicaid Services (CMS) awarded ten states grants to test Medicaid healthy behavior programs for individuals with chronic diseases. (24)

Goals and Intent

The goals of healthy behavior programs are to improve enrollee health and reduce health care costs. (24) In Iowa, HBI program goals include

- Empower members to make healthy behavior changes.

- Establish future members' healthy behaviors and rewards.

- Begin to integrate HRA data with providers for clinical decisions at or near the point of care.

- Encourage members to take specific proactive steps in managing their own health and provide educational support.

- Encourage providers to engage members in completion of the healthy behaviors by offering incentive payments to improve health outcomes.(27)

During interviews with stakeholders, stakeholders commonly said that they implemented beneficiary incentive programs to improve Medicaid beneficiaries' access to preventive services and promote personal responsibility among beneficiaries. (28) Additionally, several stakeholders believed that incentives could improve access by "getting beneficiaries in the door" for preventive services. The intent behind this goal is to improve overall health. Lastly, few stakeholders explicitly mentioned reducing costs as a rationale for incentive programs, but some stakeholders said that using incentives to link higher-cost populations (such as those with mental illness) to regular primary care could reduce costs. (28)

Activity in State

Throughout this reporting period, discussions about the state's Healthy Behavior Incentive (HBI) Program, associated Health Risk Assessments (HRA), wellness exams, and MCO-led incentive programs have occurred across public forums. While the enforcement of premiums and disenrollments associated with the HBI program are suspended during the Public Health Emergency (PHE), the process for eligibility redetermination and reinstatement of member premiums is under discussion within Iowa Medicaid for when the federal PHE ends (the state PHE ended February 15, 2022, however Medicaid's policies are impacted by the federal rather than the state PHE rules and regulations).In an

October 2020 MAAC meeting, Iowa Medicaid provided an update about member compliance with the state's HBI requirements, reporting a 17% completion rate, attributing the shortcoming (target participation rate is 40%) to difficulties driving engagement with members.(8) It should be noted that there was a point in time during the PHE when members were not held to, or required to, complete Health Behaviors; this fact may have influenced the low completion rate.

In a February 2021 MAAC meeting, Iowa Total Care provided an update that **nearly half** of its Iowa membership is enrolled in the ITC My Health Pays program, which incentives healthy behaviors, including a health risk assessment and annual wellness exam (aligned with state HBI program requirements).(29)

These reports suggest a disparity in member participation or differences in calculation of participation rates in MCO-led rewards programs. The state's HBI program includes consequences like premiums and disenrollment, in contrast, MCO rewards programs incentivize members with value-added services, outlined below:

- **Amerigroup's Healthy Rewards Program** offers members $25 to complete an annual wellness visit and $25 to complete the Health Risk Assessment.(30)

    o "Healthy Rewards dollars can be redeemed for gift cards from a variety of merchants and retails such as Amazon, Target, Kohl's, Home Depot, Domino's, Subway, Uber, and more!"

- **Iowa Total Care's My Health Pays** program offers reward for members who complete health activities, including an adult well care visit (verified by claims data) and health risk screening, with "predetermined nominal dollar amounts" (unspecified).(31)

    o "Incentives earned through the My Health Pays program are fulfilled on a reloadable Visa card, which can be used for shopping at Wal-Mart or pay for utilities, phones, transportation, education, childcare, and housing or rent expenses."

Literature and Background

The current, limited evidence on healthy behavior incentive programs is mixed in showing the overall impact on beneficiaries' health and health care costs. Inventive programs that target one-time behaviors have stronger evidence on improve health outcomes. (26) Medicaid Incentives for Healthy Behaviors, 2019). One-time or short-term activities may include filling a prescription, receiving a recommended vaccine or attending a follow-up visit. (32) Healthy behavior incentives are reportedly not as effective in changing behaviors that require ongoing maintenance, such a losing weight, exercise, a heathy diet, or smoking cessation. (24, 32) These behaviors heavily influence health care costs and utilization and require long-term behavior changes that are difficult to affect with short-term incentives. (24)

Impact on Providers

Through interviews with Medicaid stakeholders, clinicians were identified as key partners in beneficiary incentive program engagement. (28) Although clinicians are key partners, states report difficulty engaging clinicians' participation in beneficiary incentives due to limited awareness about incentive programs, no formal clinical reimbursement for participation, and difficulty integrating incentives into clinic work flows. (28) Due to the fact that clinicians interact with various program incentives, the impact of healthy behavior incentive programs may get overshadowed. (28) Ideally,

clinician and beneficiary groups would both understand and benefit from incentives included in healthy behavior programs.

Other State Examples

There is great diversity in how states and Medicaid MCOs design incentives to target various health conditions and populations. (26) For example, the Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) grant required states to target chronic disease related to behaviors and run randomized controlled trials, the 1115 waivers allow more flexibility in design and evaluation, and MCOs typically have to follow state limits on incentive amounts but have flexibility on other aspects of the incentive design. (26) Some other state programs include, but are not limited to, Arkansas Works, Healthy Indiana Plan, and Healthy Michigan Plan. Seven states (Arizona, Florida, Iowa, Indiana, Michigan, New Mexico, and Kentucky) have received a waiver to enact Healthy Behavior Incentive Programs (HBIPs), but the effects of these HBIPs on targeted health behaviors in these programs are not known. (25)

Unintended Consequences

Despite the growing experience with Medicaid beneficiary incentive programs, there is limited evidence on their effectiveness. (26) Some barriers to successful implementation of healthy behavior programs include enrollees' lack of awareness of healthy behavior incentives, lower-income populations facing environmental factors such as lack of reliable transportation, access to low-cost and convenient food options, and space and opportunities to exercise, and administrative burden and costs of implementation for the state. (24-26) A stakeholder shared in an interview that, "You can't just tell someone to go get a health risk assessment if they have no idea what a health risk assessment is or don't know the value or importance of it." (28) Additionally, imposing penalties on the financially disadvantaged Medicaid population could reduce access to needed services. (26) States report that implementing beneficiary incentive programs is more complex, time-consuming, and resource-intensive than expected. (26)

Status in Iowa

Iowa's Medicaid healthy behavior program waived premiums if participants completed specific healthy activities. Evaluation of the program's first year showed that healthy behavior completion rates were less than 17%. Interviews with enrollees and provider offices revealed low levels of awareness of the program, a lack of knowledge about how the program works, and barriers to completing activities. Evaluators went on to say that efforts to reform Medicaid by shifting responsibility to enrollees for healthy behaviors are unlikely to succeed, "especially without careful thought and design of premiums, penalties, and incentives for participants. (24)

The University of Iowa Public Policy Center has published extensive research about the Iowa Healthy Behavior Incentive Program, including investigations into outcomes, HRA completion, and implementation.[2]

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[2] https://ppc.uiowa.edu/project/healthy-behaviors-incentive-program

Communication about Policy

In Iowa, an early post-implementation analysis published just over a year after the waiver was implemented found that more than 90% of Iowa Care members were not aware that completing an annual health checkup would result in their contributions ($5-$10 per month) being waived, resulting in low incentive uptake. Communication challenges may be exacerbated among the most vulnerable of intended beneficiaries." (25)

Best Practices

Various articles and research studies discussed best practices with regards to healthy behavior incentive programs. When trying to engage beneficiaries, one stakeholder respondent replied, "members receive information and react to things differently, so you can't just treat it as a one size fits all." (28) Stakeholders suggest more person-centered engagement strategies to meet the member where they are, including foraging community partnerships. (28) Another source writes that the promised delivery of the rewards for an incentivized behavior is often far in the future in relation to the completion of the behavior. This reduces effectiveness and thus an immediate route to track and reward behavior change should be considered. (25, 33) Buntin et al., lists best practices for implementing healthy behavior programs and includes the subcategories of ensuring enrollees are aware of incentives, creating positive incentives for one-time or short-term healthy activities, and making incentives worth it (p. 15, 2017).(24) Additionally, is it suggested that as Medicaid programs experiment with changes to incentive programs, they should consider adapting strategies from employer settings. These may include improving how to communicate with beneficiaries, considering the use of support groups or health education classes, and allowing for more flexibility of incentive amount and design.(26) Finally, stakeholders reported that identifying the right technology infrastructure to implement incentive programs was especially important. States need effective data infrastructure/platforms to track healthy behaviors and trigger incentive distribution. (26)

Retroactive Eligibility Context

Status in Iowa

The Centers for Medicare & Medicaid Services (CMS) gives three reasons for approving Iowa's section 1115 waiver: it will 1) encourage "beneficiaries to obtain and maintain health coverage, even when healthy"; 2) encourage seniors and people with disabilities "to apply for Medicaid expeditiously when they meet the criteria for eligibility"; and 3) align "Medicaid and commercial coverage to facilitate smoother beneficiary transition" (34) (35) Retroactive coverage for people affected by Iowa's waiver will now begin no earlier than the first day of the application month (35) Only pregnant women, children under the age of one, children under the age of 19, and nursing home residents maintain three-month retroactive eligibility in Iowa. (36)

Iowa's waiver amendment submission to CMS indicated that "this change is being made to reduce program costs" and estimated that the "elimination of retroactive coverage is expected to reduce monthly enrollment by 3,344 enrollees and reduce annual (federal and state) Medicaid spending by $36.8 million ($9.7 state share). Specifically, the state estimated that average monthly Medicaid enrollment will decrease by 1,384 expansion adults, 1,129 children, 668 low-income parents, 157 people with disabilities, 6 seniors, and 1 breast/cervical cancer treatment enrollee as a result of the elimination of retroactive coverage. (35)

Retroactive coverage is a long-standing safeguard that has been part of Medicaid since 1972. (35, 37) Retroactive coverage provides financial security to low-income Medicaid beneficiaries and their healthcare providers, vulnerable beneficiaries, and helps to prevent medical bankruptcy and medical debt. (34, 35, 38) According to federal law, state Medicaid programs cover medical bills incurred up to three months prior to the beneficiary's Medicaid application date, provided that the beneficiary would have been eligible during that period (35, 36). When an individual is determined retroactively eligible, Medicaid will pay the provider for unpaid bills and many state Medicaid programs will also reimburse an individual who has already paid bills for covered services.(37)

Section 1115 waiver

Section 1115 of the Social Security Act authorizes the Health and Human Services (HHS) Secretary to "waive state compliance with certain provisions of federal Medicaid law to allow states to engage in experimental, pilot, or demonstration projects that further Medicaid program objectives."(38) Generally, states that have approved waivers of retroactive coverage limit retroactive coverage to the month of the application.(37) This is the nature of the retroactive waiver policy applied to the Iowa Health and Wellness Plan population.

Goals and intent

Congress created retroactive coverage 50 years ago envisioning the policy to "protect persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements or because the sudden nature of their illness precented their applying."(37, 38) Medicaid has continual open enrollment and retroactive eligibility to cover the cost of care when those who are eligible are not already enrolled before a crisis.(36) The policy's three-month retroactivity window protects people from financial ruin, helps ensure prompt access to care, and can assist families facing mounting routine medical bills including Medicare costs.(37)

Important barriers to note that increase the importance of retroactive Medicaid coverage include, but are not limited to, low-income Americans and individuals living in rural areas and inadequate internet access or smartphone accessibility. The lack of technology resources can be a barrier to applying for Medicaid when going to an office is not a safe or feasible option for individuals. (36)

Impact on providers and cost

While helping vulnerable individuals, retroactive coverage helps ensure the financial stability of health providers by paying for medical services that would otherwise go unpaid. (34) Without retroactive coverage, a person who has had an accident, for example, could owe the hospital thousands of dollars before anyone could be expected to file a Medicaid application on their behalf, and even more bills could pile up while their Medicaid application is pending. (37) Since the retroactive policies were put in place, a new policy of presumptive eligibility (PE) was established. Iowa has this as an option for members. Hospitals can do PE determinations to cover the cost of the hospital stay/event. That is a strategy employed in Iowa to mitigate the need for retroactive coverage when an individual presents to the hospital who is uninsured. Retroactive coverage reimburses hospitals and other safety net providers for care they have already provided during the three-month period which helps them to meet their daily operating costs and maintain quality of care. (34) Additionally, since the retroactive policies were put in place, a new policy of presumptive eligibility (PE) was established and is an option

for members in Iowa. Hospitals can do PE determinations to cover the cost of a hospital stay or event. This strategy is employed in Iowa to mitigate the need of retroactive coverage when an uninsured individual presents to the hospital.

Retroactive Eligibility Applications

The Department of Health and Human Services approval for 1115 waivers in Iowa, Kentucky, and New Hampshire drastically limit or completely eliminate retroactive eligibility.(36) Arizona and Florida have limited retroactive coverage for all adults, except for pregnant women, to the month of application.(36) Maryland's waiver only waives retroactive coverage for certain eligible children and New Mexico and Maine recently withdrew or suspended their retroactive coverage approval waivers.(37) In Indiana, the Family and Social Services Administration halted implementation of the waiver, limiting retroactive eligibility for everyone except for pregnant women and certain vulnerable groups, and a federal judge stayed litigation during the COVID-19 pandemic.(36)

Unintended consequences

A 2021 study focused on Section 1115 waivers of retroactive Medicaid eligibility and reported that, "Despite retroactive eligibility's long-standing role in Medicaid, little is known about how its absence affects beneficiaries and providers. Many speculated that the waivers increased uncompensated care costs for providers and medical debt for beneficiaries. But no interviewees could share evidence of this, and some expressed frustration over the lack of relevant data."(38) Despite requirements that Section 1115 waivers serve an experimental, pilot, or demonstration purpose and have an evaluation component, little is known about the impact of retroactive coverage waivers on beneficiaries and providers. (34, 35)

Cost Sharing Context

Cost sharing is an imprecise policy tool. In its simplest expression, the dominant rationale for cost sharing is to reduce "moral hazard," the tendency for comprehensively insured individuals to overuse services because they bear none of the costs for care at the time they seek it (39) The Medicaid Act exempts emergency medical services from cost sharing, but allows states to impose cost sharing on "nonemergency" use of the ED. (39)

State activity during reporting period

While the Department of Human Services reported suspending cost-sharing until the end of the Public Health Emergency, Informational Letter 2259 was issued on August 10, 2021, which delineated appropriate diagnosis codes for full emergency room claim reimbursement to providers. Previously, fully reimbursable emergency claims were required to contain an emergency diagnosis code in the primary position, but according to an IDHS informational letter in 2021, this was amended to include acceptance of a secondary emergent code. "If the primary (first) or secondary (second) diagnosis on the claim is not emergent, the member will be responsible for any applicable copay amounts."(40) Further written communication with Iowa Medicaid indicated that they still use a combination of the "prudent layperson standard" and the diagnosis code for making this communication. Additionally, if there is not an emergency diagnosis on the claim, a prudent layperson review based on medical record review is conducted.

While cost sharing in the form of an $8 copay for non-emergent use of the emergency room use were suspended during the public health emergency, member handbooks for both MCOs retained the pre-PHE policy which informed members about the circumstances of cost sharing.

In an informational letter from the state, the additional provider responsibility of verifying the member's referral source to the emergency room is included,

> *"As a reminder, the reimbursement of emergency room services is as follows:*
>
>> *1. If the emergency room visit results in an inpatient hospital admission, the visit is paid for as part of the inpatient claim.*
>>
>> *2. If the emergency room visit does not result in an inpatient hospital admission, but involves an emergent condition, reimbursement shall be made at the full Ambulatory Payment Classification (APC) payment for the treatment provided.*
>>
>> *3. If the emergency room visit does not result in an inpatient hospital admission and does not involve an emergent condition, reimbursement depends on whether the member had a referral to the emergency room:*
>>
>>> *a. Payment shall be made at 75 percent of the usual APC amount for Medicaid members who were referred to the emergency room by appropriate medical personnel.*
>>>
>>> *b. Payment shall be made at 50 percent of the usual APC amount for Medicaid members who were not referred to the emergency room by appropriate medical personnel."*

This was all a requirement from the FFCRA. During the PHE, members and providers were notified there was no cost sharing. Iowa Medicaid did not change any of our handbooks, as there were other notifications sent to clarify the policy during the PHE.

Figure 7 is an excerpt from the Iowa Total Care handbook, which delineates the provider role in determining emergency, educating members, and coordinating referrals. Expectations for payments from members are clearly included in the member handbook, which states, "You must make copays directly to provider at the time of service" and "You are always responsible for paying a provider's full charges for non-covered services."

Figure 7. Cost Sharing Decision Flow, Excerpt from Iowa Total Care Member Handbook

Emergency Care Co-payments

An eight dollar ($8) copayment for Iowa Total Care Plan Members and a twenty-five dollar ($25) copayment for Hawki Members will be applied for use of a hospital Emergency Department (ED) to treat non-emergent conditions. A copayment shall not be imposed on Hawki Members whose family income is less than 182 percent of the federal poverty level.

Before providing non-emergency services and imposing co-payments, the hospital providing care must:

1. Conduct an appropriate medical screening to determine that the Member does not need emergency services
2. Inform the Member of the amount of his or her co-payment obligation for non-emergency services provided in the hospital ED
3. Provide the Member with the name and location of an available and accessible alternative non-emergency services provider
4. Determine that the alternative provider can provide services to the Member in a timely manner with the imposition of a lesser or no co-payment
5. Provide a referral to coordinate scheduling for treatment by the alternative provider

If the Member has been advised of the available alternative provider and of the amount of the co-payment, and chooses to continue to receive treatment for a non-emergency condition at the hospital ED, the hospital will assess the co-payment.

Emergency services rendered for emergent conditions are exempt from any copayment

Definition of Policy

Premiums and cost sharing are two ways by which individuals contribute to the cost of their healthcare. (39) Premiums and cost sharing are limited, which is consistent with federal rules that take into account enrollees' limited ability to pay out-of-pocket health care costs. States may not charge premiums in Medicaid for enrollees with incomes less than 150% of the federal poverty level (FPL) in the absence of a 1115 waiver and cost-sharing amounts are limited. Additionally, through Medicaid, maximum allowable cost sharing varies by type of service and income. (41)

Goals and intent

Due to the income level of Medicaid participants and their limited ability to pay out-of-pocket costs, federal law limits the extent to which states can charge premiums and cost in order to protect Medicaid's low-income and vulnerable enrollees. (42) (39, 41)

States that have a waiver or State Plan that allows them to charge Medicaid enrollees premiums can disenroll beneficiaries who fail to pay. "The goal of payment enforcement is to ensure enrollees engage with the cost of their health care." (24) States have little recourse if enrollees do not participate in cost sharing without payment enforcement. Incentives are used in some 1115 waiver states to encourage enrollees to engage in health behaviors. These incentives include reducing or eliminating cost sharing, rolling over Health Savings Account funds, offering enhanced benefits, or providing cash rewards. (24) Goals of Section 1115 premium requirements include increasing personal responsibility and ensuring program sustainability. (42)

Status in Iowa

Before April 2016, Iowa's Medicaid health coverage operated primarily under a fee-for-service model. At the beginning of April in 2016, coverage of 94% of Medicaid members was transferred into the management of MCOs. (43)

During an audit of the State of Iowa's claims for Federal Financial Participation (FFP) for its Medicare cost-sharing payments, the Office of Inspector General found that Iowa had made State Supplementary Payments of $1 per beneficiary per month to a group of about 41,000 dual eligible.(44) By making payments, the State spent approximately $500,000 and received $39 million in FFP. (44) It should be noted that all cost sharing has been suspended during the PHE, per the Families First Coronavirus Response Act.

Additionally, the Iowa Health and Wellness Plan includes: 1) no co-payments, except $8 for using the emergency room when it is for a medical emergency, 2) no monthly contributions or premiums in the first year, 3) no contributions after the first year if the member completes preventative services and/or wellness activities, and 4) monthly contributions only for adults with income at 50.0% of the FPL or above if preventative services/wellness activities are not completed. (43)

Impact on providers and cost

Factors that drive Medicaid costs include enrollment growth, utilization in services- including trends in the health care system, changes in federal law- including changes in FMAP rate and Medicare Part D payments, and changes in State law- including new services, eligibility changes, and provider rate reimbursement changes. (43) The Families First Coronavirus Response Act provides additional options for states and increases federal funding for Medicaid, for states meeting certain eligibility and enrollment requirements. (41)

With regards to payment enforcement, disenrollment and lockout mechanisms increase the likelihood of providers not being paid for care delivered and thus, providers may be responsible for providing care for certain individuals without reimbursement. (24) States that are considering implementing cost sharing, payment enforcement, or healthy behavior programs should consider the effects on enrollees with the effects on administrative and overall health care costs. (24)

Other state examples

A study done in Arizona showed that it would cost the state $15.8 million to collect premiums and copays from enrollees while bringing in only $2.9 million in premiums and $2.7 million in copays. (24) In 2003, Utah increased premiums in their Medicaid program and individuals who were disenrolled (due to increased financial burden) reported significant unmet needs. (24) In Montana, the majority of enrollees knew that premiums were dependent on income; however, fewer Montanans were aware of the consequences for nonpayment and options for retaining or reenrolling in coverage following nonpayment (Understanding). After Georgia implemented medication copays of $2-$3, individuals with comorbidities reduced medication use and individuals with cancer reduced prescription drug use.(39)

Unintended consequences

A large body of research shows premiums serve as a barrier to obtaining and maintaining Medicaid coverage. (24, 39, 42) Cost sharing can decrease enrollment, decrease access to essential health care, and increase use of more expensive health care services such as the emergency department.(24) States may

also experience increased administrative burden when implementing cost sharing with enrollees.(24) "Even relatively small levels of cost-sharing are associated with reduced care, including necessary services, as well as increased financial burden for families; and state savings from premiums and cost-sharing in Medicaid are limited."(42)

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