

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00289/5
TITLE: Iowa Wellness Plan
AWARDEE: Iowa Department of Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Iowa Wellness Plan section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable Iowa to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of a requirement under section 1902(a) of the Social Security Act (the Act). These STCs set forth in detail the nature, character and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. Enrollment activities for the new adult population began on October 1, 2013 for the Iowa Wellness Plan with eligibility effective January 1, 2014. The demonstration will be statewide and is approved through December 31, 2016.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
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- VIII. Appeals
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II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the approved Iowa Wellness Plan demonstration, for the new adult population that is eligible under the state plan group described in section 1902(a)(10)(A)(i)(VIII) and is not affected by the Marketplace Choice Plan demonstration, the state will be relieved of its responsibility to assure non-emergency transportation to and from providers for a one year

period. Through this demonstration, the state will test and evaluate the effect of this change in state responsibilities on beneficiary access and utilization of services, and overall health status.

The Iowa Wellness Plan demonstration contains an incentive program that is intended to improve the use of preventive services and other healthy behaviors. Monthly premiums for enrollees with incomes between 50 percent and 100 percent of the FPL can be imposed in year 2 of the demonstration and shall be waived if enrollees complete all required healthy behaviors during year 1 of the demonstration. For each subsequent year, enrollees will have the opportunity to complete healthy behaviors and to continue to have their financial contributions waived based on those activities, i.e., healthy behaviors performed in year 2 will be permitted to waive premiums for year 3. At state option, nonpayment of these premiums can result in a collectible debt, but not loss of coverage for the enrollee. The authority enabling the state to begin charging premiums in year 2 is subject to a quarterly aggregate cap of 5 percent of family income.

With this demonstration Iowa proposes to further the objectives of title XIX by:

- Improving enrollee health and wellness through healthy behaviors and use of preventive services.
- Increasing enrollee engagement and accountability in their health care.
- Increase enrollee access to dental care

Iowa proposes to demonstrate whether monthly contributions and incentives for healthy behaviors improve enrollee health, , and increase use of preventive services and healthy behaviors, without reducing access to care. Through the dental amendment, Iowa proposes to further this objective by providing tiered enhanced dental benefits to beneficiaries who active management of their oral health through the completion of periodic exam incentives. In addition to the guaranteed basic Core benefits through the Wellness Alternative Benefit Plan (ABP), beneficiaries who return for a periodic exam within 6-12 months of their first visit will qualify for Enhanced benefits, and Enhanced Plus benefits for beneficiaries who return for a second periodic exam within 6-12 months after the first periodic exam.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advanced of the expected approval date of the amended STCs to allow the state to provide comment.

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
- b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. State Plan Amendments. The state will not be required to submit Title XIX or XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.

Should the state amend the state plan to make any changes to eligibility for any population affected by the demonstration, upon submission of the state plan amendment, the state must notify CMS for demonstration staff in writing of the pending state plan amendment, and request any necessary corresponding technical corrections to the demonstration.

6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

- a. An explanation of the public process used by the state, consistent with the requirements of STC 15, prior to submission of the requested amendment;
- b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
- d. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in STC 29; and
- e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the State must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 9.

- a. Compliance with Transparency Requirements at 42 CFR §431.412.
- b. As part of the demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.

9. Demonstration Phase Out. The State may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The State must submit its notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the State must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received the State's response to the comment and how the State incorporated the received comment into the revised plan.
- b. The State must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.
- c. Transition and Phase-out Plan Requirements: The State must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.
- d. Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR §435.916.
- e. Exemption from Public Notice Procedures 42.CFR §431.416(g). CMS may expedite the federal and State public notice requirements in the event it determines that the objectives

of title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

- 10. Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments in the quarterly report associated with the quarter in which the forum was held. The State must also include the summary in its annual report.
- 11. Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.
- 12. Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:
 - a. **Expiration Requirements:** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
 - b. **Expiration Procedures:** The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
 - c. **Federal Public Notice:** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan

prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

- d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

13. Withdrawal of Waiver Authority. CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration are proposed by the state.

- a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).
- b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).
- c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. Federal Financial Participation (FFP). No federal matching for administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. POPULATIONS AFFECTED

17. Iowa Wellness Plan Population.

The Iowa Wellness Plan is targeted for who are eligible in the new adult group under the State plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act, and 42 CFR § 435.119, who are not affected by the Marketplace Choice Plans demonstration, and who receive the ABP that is the Iowa Wellness plan.

V. DENTAL DELIVERY SYSTEM

- 18. Overview.** The Iowa Wellness Plan will provide dental services through a managed care delivery system known as a Prepaid Ambulatory Health Plan (PAHP).
- 19. Managed Care Requirements.** The state must comply with the managed care regulations published at 42 CFR §438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR §438.6. The certification shall identify historical utilization of services that are the same as outlined in the corresponding Alternative Benefit Plan and used in the rate development process.
- 20. Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR §438 requirements prior to CMS approval of this demonstration authority as well as such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.
- 21. Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).
- 22. Managed Care Dental Benefit Package.** Individuals enrolled in the Iowa Wellness Plan will receive from the managed care program the benefits as identified in Section VI of the STCs. Covered dental benefits should be delivered and coordinated in an integrated fashion.
- 23. Enrollment Requirements.** The state may require any of the populations identified in Section IV to enroll in PAHPs.

- a. Mandatory enrollment may occur only when the PAHP(s) has been determined by the state to meet readiness and network requirements to ensure sufficient access, quality of care, and care coordination for beneficiaries as established by the state, consistent with 42 CFR §438 and as approved by CMS.
 - b. In all areas of the state, individuals will only be permitted to enroll in the single PAHP that serves their area of residence.
 - c. All individuals will be automatically assigned to the single PAHP that serves beneficiaries in their area of residence in order to access services in their dental benefits.
24. **Network Requirements.** The state must ensure the delivery of all covered dental benefits, including high quality care. Services must be delivered in a culturally competent manner, and the PAHP network must be sufficient to provide access to covered services to the low-income population. The following requirements must be included in the state's PAHP contracts:
- a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. §438.208(c)(4).
 - b. **Out of Network Requirements.** The PAHP must provide demonstration populations with all demonstration program benefits under their contract and as described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the state.
25. **Demonstrating Network Adequacy.** Annually, the PAHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of providers necessary to provide covered services for the anticipated number of enrollees in the service area.
- a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
 - i. The number and types of dentists and dental specialty providers available to provide covered services to the demonstration population
 - ii. The number of network providers accepting the new demonstration population; and
 - iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.
 - b. The state must submit the documentation required in subparagraphs i – iii above to CMS with initial PAHP contract submission as well as at each contract renewal or renegotiation, or at any time that there is a significant impact to the PAHP's operation, including service area expansion or reduction and population expansion.

VI. BENEFITS

26. Iowa Wellness Plan Benefits. Individuals affected by this demonstration will receive benefits including Core benefits described in the Iowa Wellness Plan alternative benefit plan (ABP), except for enhanced benefits provided in the Dental Wellness Plan under this demonstration.

27. Dental Wellness Plan. Individuals affected by this demonstration will qualify for Enhanced or Enhanced Plus dental benefits earned through completion of periodic exam incentives. Benefits are explained in Table 1. The State must provide member hotline assistance to individuals seeking dental care who were unable to secure an appointment with a dental provider. The State must take action to assist beneficiaries in accessing services if they report to the State, in a timely manner, that they were not able to secure a dental appointment through the PAHP. Where attempts to make an appointment have been verified, but the beneficiary was still unable to access services, the State must provide an exemption to the periodic exam incentive requirements to any beneficiary who has a demonstrable dental need for services contained in either the Enhanced or Enhanced Plus earned benefit tiers.

Table 1. Dental Wellness Plan Benefits under the Demonstration

	Enhanced	Enhanced Plus (subject to prior authorization)
Benefits Available	<p>All Core benefits as described in the Wellness ABP and the following:</p> <ul style="list-style-type: none"> • Restorations and other restorative services • Root Canals, apexification, apicoectomy, and other endodontic services • Non-surgical gum treatment • Denture adjustments, repairs, relines (limit 2 per 12 months) • Non-surgical and surgical extractions and other Oral Surgery services • Designated adjunctive 	<p>All Core benefits as described in the Wellness ABP, all Enhanced Benefits, and the following:</p> <ul style="list-style-type: none"> • Crowns/onlays – for anterior permanent teeth with extensive coronal destruction/broken cusp and posterior teeth with root canal therapy and cracked tooth syndrome • Tooth Replacements: <ul style="list-style-type: none"> ○ Dentures (partial) – for replacing anterior teeth and posterior teeth when there are fewer than eight teeth in occlusion or when required to

	services	<p>balance the occlusion</p> <ul style="list-style-type: none"> ○ Dentures (Complete) –for edentulous ○ Bridges (only covered for designated clinical conditions in which a partial denture is contraindicated. <ul style="list-style-type: none"> ● Gum Surgery
Beneficiary Action to Earn Benefits	<p>Return for a periodic exam within 6 – 12 months of first visit*</p> <p>* The initial follow up visit is either the first follow up visit upon enrolling into the Iowa Health and Wellness Plan and receiving the first exam OR the first follow up visit after starting over due to non-compliance.</p>	<p>Return for a second periodic exam within 6 – 12 months of the first periodic exam*.</p> <p>* The first periodic exam refers to when the beneficiary became eligible for Enhanced Benefit Tier.</p>
Beneficiary Action to Maintain Earned Benefits	<p>Return for 1 periodic exam every 6 – 12 months of previous periodic exam.</p>	<p>Return for 1 periodic exam every 6-12 months from previous periodic exam.</p>

Beneficiaries who return for a periodic exam within 6 – 12 months of first visit will qualify for enhanced benefits. Beneficiaries who return for a second periodic exam within 6 – 12 months of the first periodic exam will qualify for additional enhanced benefits (Enhanced Plus). Failure to comply with the periodic exam incentives described in Section VI for maintaining earned benefits will preclude the beneficiary’s further access to Enhanced or Enhanced Plus services and the beneficiary will revert to the Core benefits described in the Wellness ABP. Beneficiaries have access to all emergency services in the Core benefit if they are unable to access the Enhanced or Enhanced Plus tiers. Beneficiaries will be able to challenge any denial in whole or

in part, limited authorization of service, termination of a previously authorized service, of failure of a plan to act within the required timeframe as described in Section VII of the STCs.

28. Non-Emergency Medical Transportation (NEMT). Individuals affected by this demonstration shall not benefit from any administrative activity or service to assure non-emergency transportation to and from providers. This waiver authority will sunset after one year, to allow for reevaluation of this authority; the state and CMS will consider the impact on access to care.

VI. HEALTHY BEHAVIORS, PREMIUMS AND COST SHARING

29. Premiums.

- a. Authority to charge premiums is subject to the CMS approval of the protocols described in STC 33 and the state's ability to demonstrate statewide access under the standards set forth in STC 33(a)(ix).
- b. No premium will be charged for the first year of enrollment in the Iowa Wellness Plan.
- c. All premiums permitted by this paragraph are subject to the exemptions and waivers described in STC 30.
- d. Monthly premium amounts may not exceed \$5/month for nonexempt households from 50 up to 100 percent of the FPL and \$10/month for nonexempt households between 100-133 percent of the FPL.
- e. Enrollees will be allowed a 90 day premium grace period.
- f. The enrollee may not be disenrolled for nonpayment of a premium, nor can an individual be denied an opportunity to re-enroll due to nonpayment of a premium.
- g. After 90 days, unpaid premiums may be considered a collectible debt owed to the State of Iowa and, at state option, subject to collection by the state, with the following exception:
 - i. If, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment, unpaid premiums shall not be considered a collectible debt by the state.

30. Premium Exemptions. Iowa Wellness Plan enrollees will be exempt from a monthly contribution obligation under the following conditions:

- a. For all individuals enrolled in the Iowa Wellness Plan, premiums are waived in the first year of the individual's enrollment. Premiums will continue to be waived in subsequent years if enrollees complete healthy behaviors in their prior annual period as outlined in the Healthy Behavior Incentive Protocol once approved as Attachment A.
- b. Premiums may only be assessed on non-exempt individuals as described in 42 CFR 447.56.

- c. Medically frail and members in the HIPP population are not subject to premiums.
- d. All individuals who self-attest to a financial hardship will have no premium obligation. The opportunity to self-attest will be made available with each invoice.

31. Copayment for non-emergency use of the emergency department. Premiums shall be in lieu of other cost sharing except that the state may impose a copayment for non-emergency use of the emergency room consistent with its approved state plan and with all federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR § 447.56.

32. Iowa Wellness Plan Healthy Behaviors. Authority to implement the Healthy Behaviors component is subject to the CMS approval of the protocols described in STC 24 Enrollees who do not complete required healthy behaviors will be required to pay their monthly premiums beginning in the next enrollment year.

- a. **General Description.** All individuals subject to premiums who are enrolled in the Iowa Wellness Plan will have premiums waived in year 1 and will be eligible to receive a waiver of monthly premium contributions required in year 2 of enrollment if enrollees complete healthy behaviors during year 1 of enrollment. For each subsequent year, nonexempt enrollees will have the opportunity to complete healthy behaviors to continue to waive financial contributions, i.e. healthy behaviors performed in year 2 will be permitted to waive premiums for year 3.
- b. **Healthy behaviors.** The conditions to be met by a nonexempt individual in year 1 of enrollment as a condition for not being liable for monthly contributions in year 2 are completing a health risk assessment and wellness exam (annual exam). A health risk assessment is considered part of the individual's medical record and is afforded all associated privacy and confidentiality protections afforded to such documents by federal and state law, regulations, and policy.
- c. **Grace Period.** Nonexempt individuals will be given a 30 day healthy behavior grace period. If the individual completes the required healthy behaviors in the first 30 days of year when premiums are due, no premiums will be due for the remainder of the year.

33. Healthy Behaviors and Premiums Protocols. Authority to charge premiums and to implement the Healthy Behaviors component described in this section shall apply to the extent that the state establishes the protocols, subject to CMS approval, described here:

- a. **Year 1 Healthy Behaviors and Premiums Protocols.** By March 31, 2014, the state shall submit for approval a protocol describing the state's plan for implementing year 1 Healthy Behavior Incentives and Premiums including, at a minimum, the following:

Healthy Behaviors

- i) The purpose and objectives of the Healthy Behaviors Incentive program.
- ii) The methodology for obtaining, and content of, the health risk assessment used to identify unhealthy behaviors such as alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.
- iii) The criteria to be met for completing a wellness exam.
- iv) The process by which an enrollee is deemed compliant with healthy behaviors in year 1.
- v) The positive incentives that could be used both for purposes of reducing premiums or other health-related purposes, and the amount of positive incentives that can be earned on an annual basis which should be at least as much as the annual premium contributions required.
- vi) A list of stakeholders consulted in the development of the protocol.
- vii) A description of how healthy behaviors will be tracked and monitored at the enrollee and provider levels, including standards of accountability for providers.
- viii) A description of how the state will notify and educate enrollees about the Healthy Behaviors Incentives program.
- ix) Access data standards for which the state will supply baseline data establishing statewide access per STC 25 to allow for CMS approval of year 2 premium implementation:
 - (1) Statewide Access Standards. The state must achieve in any preceding year to the implementation of the premiums (and continue to maintain or improve), at a minimum, all of the following standards.
 - (a) Statewide and/or regional access standards
 - (b) Medicaid network slots to member ratio standards
 - (c) Access to care standards including timeliness and actual primary care utilization in the enrolled population.
 - (d) NCQA Element B standards
 - (e) Data from monitoring of member hotline/complaint mechanism
 - (f) Data from consumer surveys

Premiums

- x) The process by which the state will identify individuals who are exempt from the premium requirements
- xi) The notices beneficiaries will receive regarding premiums and/or Healthy Behaviors and the schedule for such notices.
- xii) The process by which beneficiaries will be able to remit payment, including ways individuals who cannot pay by check will be accommodated.
- xiii) The process by which the state will collect past due premiums.

- b. **Future Year Healthy Behaviors Incentives Standards.** By August 1, 2014 (and succeeding years), the state will submit for approval, the protocol with the following Healthy Behaviors Incentive Program standards:

- i) A description of any provisions that will be provided to assist enrollees in addressing unhealthy behaviors identified through the health risk assessment.
 - ii) A description of selected healthy behaviors to be met by an individual in year 2 (or subsequent years), whereas, an individual will be deemed compliant with healthy behaviors resulting in a waiver of monthly contributions in year 3 (or subsequent years). Iowa will further evaluate, define and refine healthy behavior requirements for subsequent years of the demonstration. Iowa must obtain CMS approval before the state can introduce new requirements to enrollees.
 - iii) Any access data standards and an updated monitoring protocol related to healthy behaviors to be met in year 2 (or subsequent years).
- c. **Premium Monitoring Protocols.** By August 1, 2014 the state will submit for approval, criteria by which the state will monitor premiums and thresholds for modification and/or termination of premium collection in the event of unintended harm to beneficiaries. This monitoring shall include data related to premium payment/non-payment. The state shall include the data it will report to CMS in quarterly reports which must include but is not limited to the number of:
- i) Individuals subject to premium requirements (i.e. number of nonexempt individuals),
 - ii) Individuals whose premiums have been waived due to compliance with healthy behaviors,
 - iii) Individuals exempt due to hardship.
 - iv) Individuals with overdue premiums including those with premiums past due less than and greater than 90 days.
 - v) Information about the state's collection activities.
 - vi) The number of individuals who have premiums that have become collectible debt.
- d. **CMS Review of the Protocols.** Once approved by CMS, the Healthy Behaviors and Premiums Protocols will become Attachment A of these STCs, and will be binding upon the state. The state may request changes to the approved Healthy Behaviors and Premiums Protocols, which must be approved by CMS, and which will be effective prospectively.

34. Data Establishing Statewide Access. The state will supply baseline data, in accordance with the protocol approved in STC 33(a)(ix), establishing statewide access by August 1, 2014, to allow for CMS approval of year 2 premium implementation

VII. APPEALS

35. Beneficiary safeguards of appeal rights will be provided by the State, including fair hearing rights. No waiver will be granted related to appeals. The State must ensure compliance with all federal and State requirements related to beneficiary appeal rights. Pursuant to the Intergovernmental Cooperation Act of 1968, the State may submit a State Plan Amendment delegating certain responsibilities to the Iowa Insurance Division or another state agency.

Dental services appeals are governed by the contract between the State and the dental

managed care organization.

VIII. GENERAL REPORTING REQUIREMENTS

36. General Financial Requirements. The State must comply with all general financial requirements under Title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section XI of these STCs.

37. Reporting Requirements Related to Budget Neutrality. The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section XI of these STCs.

38. Monthly Monitoring Calls. CMS will convene periodic conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the Marketplace Choice plan beyond December 31, 2016. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls. Areas to be addressed include, but are not limited to:

- a. Transition and implementation activities,
- b. Stakeholder concerns,
- c. ACO and MCO operations and performance,
- d. Enrollment,
- e. Cost sharing,
- f. Quality of care,
- g. Access,
- h. The benefit package,
- i. Audits,
- j. Lawsuits,
- k. Financial reporting and budget neutrality issues,
- l. Progress on evaluations,
- m. Legislative developments, and
- n. Any demonstration amendments the state is considering submitting.

39. Quarterly Progress Reports. The state will provide quarterly reports to CMS.

- a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. For the dental benefit, the State must report on a quarterly basis how many people had a dental need but could not access an appointment in a timely manner based on member services call data.

- b. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.

40. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the State shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.

41. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The State will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the demonstration year (DY) to CMS.

- a. All items included in the quarterly report pursuant to STC 39 must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and
- c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

42. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

IX. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

43. Quarterly Expenditure Reports. The State must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in section XII of the STCs.

44. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

- a. Tracking Expenditures. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM.

All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, “expenditures subject to the budget neutrality limit,” is defined below in STC 60.

- b. **Cost Settlements.** For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (form CMS-64.9P Waiver) for the summary sheet line 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.
- c. **Premium and Cost Sharing Contributions.** To the extent Iowa collects premiums, Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
- d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver or 64.9 Waiver schedules and allocated to forms named for different EGs described below as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to demonstration populations shall be offset against expenditures.
- e. **Use of Waiver Forms for Medicaid.** For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:
 - i. MEG 1 – “New Adult Group”

- f. The first Demonstration Year (DY1) will begin on January 1, 2014. Subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	January 1, 2014	12 months
Demonstration Year 2 (DY2)	January 1, 2015	12 months
Demonstration Year 3 (DY3)	January 1, 2016	12 months

45. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name State and Local Administration Costs (“ADM”).

46. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

47. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under STC 30, the actual number of eligible member months for the demonstration populations. The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

- b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

48. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The State must estimate matchable demonstration

expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

49. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in STC 61:

- a. Administrative costs, including those associated with the administration of the demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
- c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

50. Sources of Non-Federal Share. The State must certify that the matching non-federal share of funds for the demonstration are state/local monies. The State further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The State assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

51. State Certification of Funding Conditions. The State must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the State utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for federal match.
- d. The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

52. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 54, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality

expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

53. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for demonstration populations, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

54. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 55 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 47 below.

55. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of demonstration service expenditures for the tiered dental benefits will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC 63. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.

MEG	TREND	DY 1 – Dental PMPM	DY 2 – Dental PMPM	DY 3 – Dental PMPM
New Adult Group	4.7%	\$ 24.71	\$ 25.87	\$ 27.09

If the State's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

- a. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.
- b. The State will not be allowed to obtain budget neutrality “savings” from this population.

56. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

57. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

58. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the State’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the State must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	3%
DY 2	Cumulative budget neutrality limit plus:	1.5%
DY 3	Cumulative budget neutrality limit plus:	0%

59. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS.

If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

VII.EVALUATION

- 60. Submission of Draft Evaluation Design.** The state shall submit an amended draft evaluation design including details on evaluation of the healthy behaviors protocol of the dental benefit and delivery system to CMS no later than 60 days after the award of the demonstration. CMS shall provide comment within 30 days of receipt from the state.
- 61. Submission of Final Evaluation Design.** The state shall provide the Final Evaluation Design within 30 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within 30 days.
- 62. Evaluation Requirements.** The State shall engage the public in the development of its evaluation design. The evaluation design shall incorporate a final evaluation and will discuss the following requirements as they pertain to each:
- a. The scientific rigor of the analysis;
 - b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
 - c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
 - d. Data strategy including sources of data, sampling methodology, and how data will be obtained;
 - e. The unique contributions and interactions of other initiatives; and
 - f. How the evaluation and reporting will develop and be maintained.

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The State shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the State will assure no conflict of interest, and a budget for evaluation activities.

- 63. Evaluation Design.** The Evaluation Design shall include the following core components to be approved by CMS:
- a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, improving

quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will be examined using appropriate comparison groups and studied in a time series. The amended draft evaluation should include robust metrics and methods for evaluating the healthy behaviors incentives component and dental benefits that take effect on May 1, 2014.

The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

- i. Not assuring non-emergency transportation has no impact on healthy behaviors and does not pose a barrier to access to care.
 - ii. Health and Wellness enrollees will use preventative care services at a greater rate.
 - iii. Health and Wellness beneficiaries will have satisfactory access and experience without a non-emergency transportation benefit.
 - iv. Additional types of payments above the regular fee-for-service payment for Primary Care Physicians (PCPs) incentive wellness activities in Health and Wellness enrollees will increase preventative services at a greater rate.
 - v. Premiums incentivize enrollees to complete healthy behaviors and do not pose an access to care barrier.
 - vi. Beneficiaries will experience greater access to dental providers.
- b. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality including consumer satisfaction and other indicators of consumer experience.
- c. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered.
- d. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.
- e. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the demonstration. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly

defined. To the extent possible, the State will incorporate comparisons to national data and/or measure sets. A broad set of performance metrics will be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care. The State must include a study of network adequacy for dental providers using beneficiary survey data on access.

- f. **Data Collection:** This discussion shall include a description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:
 - i. Medicaid encounter and claims data,
 - ii. Enrollment data,
 - iii. Provider Network data,
 - iv. Consumer and provider surveys, and
 - v. Other data needed to support performance measurement relative to access and quality metrics.

- g. **Assurances Needed to Obtain Data:** The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available including from health plans.

- h. **Data Analysis:** This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.

- i. **Timeline:** This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

- j. **Evaluator:** This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

64. Public Access. The State shall post the final approved Evaluation Design on the State Medicaid website within 30 days of approval by CMS.

- 65. Electronic Submission of Reports.** The State shall submit all required plans and reports using the process stipulated by CMS, if applicable.
- 66. Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, the State shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.
- 67. Cooperation with Federal Learning Collaboration Efforts.** The State will cooperate with improvement and learning collaboration efforts by CMS.
- 68. Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.
- 69. Final Evaluation and Implementation.** The State must implement the evaluation design, and submit to CMS a draft of the evaluation 120 days after the expiration of the demonstration. CMS shall provide comments within 60 days of receipt of the draft evaluation. Within 60 days of receipt of comments from CMS, a revised final report must be submitted. The State must provide an interim evaluation on access during the first 12 months of access to the enhanced dental benefit.
- 70. Deferral for Failure to Provide Final Evaluation Reports on Time.** The State agrees that when Final Evaluation Reports are due, CMS may issue deferrals in the amount of \$5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

VIII. MONITORING

- 71. Evaluation Monitoring Protocol.** The State shall submit for CMS approval a draft monitoring protocol no later than 60 days after the award of the demonstration. The protocol is subject to CMS approval. CMS shall provide comment within 30 days of receipt from the State. The State shall provide the final protocol within 30 days of receipt of CMS comments. If CMS finds that the final protocol adequately accommodates its comments, then CMS will approve the final protocol within 30 days.
- a. The monitoring protocol, including metrics and network characteristics shall align with the CMS approved evaluation design.

- b. The State shall make the necessary arrangements to assure that the data needed from the health plans, and data needed from other sources, are available as required by the CMS approved monitoring protocol.
- c. The monitoring protocol and reports shall be posted on the State Medicaid website within 30 days of CMS approval.

72. Quarterly Evaluation Operations Report. The State will provide quarterly reports to CMS. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration. The reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

73. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics, including their specifications, reporting cycles, level of reporting (e.g., the State, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under the Health and Wellness Plan, and for monitoring and evaluation of the demonstration.

XV. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

74. Health Information Technology (HIT). The State will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The State is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

- a. Health IT: Iowa must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified electronic health record (EHR) technology and the ability to exchange data through the State's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.
- b. The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing health information exchange (HIE) infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers. The State must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.
- c. All requirements must also align with Iowa's State Medicaid HIT Plan and other planning efforts such as the ONC HIE Operational Plan.

XVI. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, “Transformed Medicaid Statistical Information System (T-MSIS) Data”, was released. It states that all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Iowa against which the premium assistance demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the SMM Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.