CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W00288/5**

TITLE: **Iowa Marketplace Choice Plan**

AWARDEE: **Iowa Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Iowa Marketplace Choice Plan section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable Iowa to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act), and expenditure authority authorizing federal matching of demonstration costs no otherwise matchable, which are separately enumerated. 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. The STCs are effective on the date of the signed approval. Enrollment activities for the new adult population began on October 1, 2013 for the Iowa Marketplace Choice 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
III. General Program Requirements
IV. Populations Affected
V. Iowa Marketplace Choice Plan Enrollment
VI. Premium Assistance Delivery System
VII. Benefits
VIII. Healthy Behaviors, Premiums, and Cost Sharing
IX. Appeals
X. General Reporting Requirements
XI. General Financial Requirements
XII. Monitoring Budget Neutrality
XIII. Evaluation
XIV. Monitoring
XV. Health Information Technology and Premium Assistance
XVI. T-MSIS Requirements

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Iowa Marketplace Choice Plan demonstration, the State will provide premium assistance and assistance in paying cost sharing for individuals with income above 100 percent of the federal poverty line (FPL) who are eligible in the state plan eligibility group described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (Act) and who are neither medically frail nor eligible for cost-effective employer-sponsored insurance (the Marketplace Choice Plan population), to enable such individuals to enroll in coverage offered by a designated Qualified Health plan (QHP) in the individual market through the Marketplace. Such individuals are ages 19 through 64 with income above 100 percent of the federal poverty line (FPL) up to and including 133 percent of the FPL.

The Iowa Marketplace Choice 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 above 100 percent of the FPL, up to and including 133 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.

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. We have provided authority to enable the state to not provide non-emergency medical transportation for individuals in the Marketplace Choice demonstration. This waiver authority will sunset after one year, to allow for reevaluation of this authority to allow for the state and CMS to consider the impact on access to care.

The Marketplace Choice Plan population will be entitled to a State plan Alternative Benefit Plan (ABP) specified in the approved state plan. Primary payment for services will be made by the QHP that they select to enroll in. Individuals in this population may have a premium obligation under the terms of this demonstration, but such obligations will be reduced or eliminated for beneficiaries who obtain preventative services or engage in healthy behaviors.

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

- Promoting continuity of coverage for individuals who are near the income eligibility threshold for individual coverage by facilitating their enrollment in individual coverage,
- Improving access to providers through the availability of payment for services by QHPs at market rates, and
- Furthering quality improvement and delivery system reform initiatives through incentives for beneficiaries to obtain preventive services and engage in health behaviors.

Iowa proposes to demonstrate the following key features:

- Whether offering multiple plan options to the Marketplace Choice Plan population that align with options available in the individual market will promote continuity of coverage for individuals;

- Whether the availability of third party payment for services at market rates will improve access to needed services;
- Whether reduced premiums can be an incentive for beneficiaries to use preventative services and engage in other healthy behaviors; and
- Whether removing state responsibility to ensure that beneficiaries have needed non-emergency transportation to and from providers will result in decreased beneficiary access to covered services.

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 this population, 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 a corresponding technical correction 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 69; 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 as specified in STC 44 associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in STC 46.

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 administration or service expenditures related only to the implementation of this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. POPULATIONS AFFECTED

Under this demonstration, Marketplace Choice Plan Population will be required to enroll in coverage offered by designated QHPs through the Marketplace. The QHPs will pay primary to Medicaid for covered services, and the Marketplace Choice Plan population will be required to receive services from providers that participate in the QHP network instead of the delivery system that serves the traditional Medicaid population. The State will provide premium assistance to aid individuals in the Marketplace Choice population in enrolling in coverage offered by QHPs through the Marketplace.

17. Iowa Marketplace Choice Plan Population. Except as described in STCs 18 and 19, the Iowa Marketplace Choice Plan Demonstration affects the delivery of benefits, to adults aged 19 through 64 eligible under the State plan eligibility group that is described in 1902(a)(10)(A)(i)(VIII) of the Act who have incomes from 100 percent up to and including 133 percent of the FPL. Eligibility and coverage for these individuals is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as expressly waived in this demonstration.

Medicaid State Plan Mandatory Groups	Federal Poverty Line	Funding Stream	Expenditure and Eligibility Group Reporting
Parent and caretaker relatives as well as the childless adults, who are eligible in the new adult state plan eligibility group described in section 1902(a)(10)(A)(i)(VIII) who are neither medically frail nor eligible for cost-effective employer sponsored insurance.	From 100 percent of the FPL up to and including 133 percent of the FPL	Title XIX	MEG – 1

18. Exemptions. The process for determining whether an individual is medically frail or has access to cost effective employer sponsored insurance is described in the approved Iowa state plan.

19. Option for American Indian/Alaska Native Individuals. Individuals identified as American Indian or Alaskan Native (AI/AN) who are described in the Marketplace Choice population will not be affected by this demonstration unless an individual so chooses. Individuals who are AI/AN and who have not opted in to the Marketplace Choice Plan will not be required to enroll in a QHP and will receive coverage as described in the approved state plan..

V. MARKETPLACE CHOICE PLAN PREMIUM ASSISTANCE ENROLLMENT

20. Marketplace Choice. For the Marketplace Choice Plan population, enrollment in a designated QHP will be a condition of receiving benefits.

21. Notices. Marketplace Choice plan population beneficiaries will receive a notice from Iowa Medicaid advising them of the following:

a. QHP Plan Selection. The notice will include information regarding how Marketplace Choice plan beneficiaries can select a QHP. The state will ensure that the beneficiary authorizes the state to select plans for them if they do not choose a plan

b. Access to Services until QHP Enrollment is Effective. The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP enrollment is effective.

c. Direct State Plan Benefits (supplementing QHP covered benefits). The notice will also include information on how beneficiaries can use the CIN number to access direct state plan benefits. The notice will include specific information regarding services that supplement QHP benefits and are covered directly through Medicaid, what phone numbers to call or websites to visit to access direct services, and any cost-sharing for wrapped services pursuant to STC 31.

d. Appeals. The notice will also include information regarding the grievance and appeals process.

e. Exemption from the Alternative Benefit Plan. The notice will include information describing how Marketplace Choice plan beneficiaries who believe they may be exempt from the Marketplace Choice ABP, and individuals who are medically frail, can request a determination of whether they are exempt from this ABP. This notice will describe how beneficiaries seeking to participate in the Marketplace Choice premium assistance can opt out of the medical frailty screening during the QHP selection process..

22. QHP Selection. The QHP in which Marketplace Choice plan population beneficiaries will enroll will be certified through the Iowa Insurance Division's QHP certification process.

The QHPs available for selection by the beneficiary will be determined by the Medicaid agency.

23. Enrollment Process. Individuals in the Marketplace Choice Plan population will begin to enroll during the initial QHP enrollment period (October 1, 2013 – March 31, 2014) through the following process:

a. Individuals will submit a joint application for insurance affordability programs—Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions—electronically, via phone, by mail, or in-person.

b. A Medicaid eligibility determination will be made either through the Marketplace or the Iowa Department of Human Services.

c. Once individuals have been determined Medicaid-eligible in the new adult population, they will have an opportunity to complete the health care needs questionnaire, to be assessed for medical frailty as defined in STC 18. They will also have an opportunity to opt-out of the medical frailty assessment if they prefer to enroll in the Marketplace Choice demonstration. Individuals will be notified of the potential consequences of a medical frailty designation as part of the screen offering an opt-out.

d. A determination of availability of cost-effective employer-sponsored insurance will be made.

e. A determination of AI/AN status and offering option to opt in to Marketplace Choice.

f. Individuals who are determined to be in the Marketplace Choice plan population will have an opportunity to shop among QHPs available to Marketplace Choice plan eligible individuals.

g. The State's MMIS will capture their plan selection information and will transmit the enrollment transactions to the QHP issuers.

h. QHP issuers will issue insurance cards to Marketplace Choice plan enrollees.

i. The State's MMIS will issue payments for premiums on behalf of beneficiaries directly to the QHP issuer.

j. State MMIS premium payments to the selected QHP issuer will continue until the individual is determined to no longer be eligible for Medicaid; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be medically frail or has access to cost effective ESI.

k. In the event that an individual is determined eligible for coverage through the Marketplace Choice Plan, but does not select a plan, the State ensure that the beneficiary authorizes the state to select plans for them if they do not choose a plan.

24. Disenrollment. Enrollees in the QHP as part of Marketplace Choice plan may be disenrolled if they are determined to be medically frail after they were previously determined eligible.

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

25. QHP MOU. The Iowa Medicaid Enterprise and the Iowa Insurance Division shall enter into a memorandum of understanding (MOU) with each QHP that will enroll individuals covered under the Demonstration within 60 days of the effective date of the STCs. Areas to be addressed in the MOU include, but are not limited to:

a. Enrollment of individuals in populations covered by the Demonstration;
b. Methods for payment of premiums and cost-sharing amounts on behalf of beneficiaries;
c. Reporting and data requirements necessary to monitor and evaluate the Marketplace Choice plan including those referenced in STC 69, ensuring enrollee access to EPSDT and other covered benefits through the QHP; and
d. Noticing requirements; and audit rights.

26. Qualified Health Plans (QHPs). The State will use premium assistance to support the beneficiary's purchase of coverage for Marketplace Choice plan beneficiaries through Marketplace QHPs.

27. Choice. Each Marketplace Choice Plan population beneficiary will have the option to choose between at least two silver plans offered in the individual market through the Marketplace. The State will pay the full cost of QHP premiums on behalf of the beneficiary.

a. Marketplace Choice plan population beneficiaries will be able to choose from at least two silver plans in each rating area of the State.

b. Marketplace Choice plan population beneficiaries will be permitted to choose among the silver plans offered to Medicaid members. All Marketplace Choice plan beneficiaries will have a choice of at least two QHPs in their geographic area.

c. The Essential Community Provider network requirements will be applied by the state as part of the QHP certification process.

d. Marketplace Choice plan beneficiaries will have access to the same networks as other individuals enrolling in the same silver level QHP.

28. Coverage Prior to Enrollment in a QHP. The State will provide direct coverage through Medicaid from the date an individual is determined to be in the Marketplace Choice plan population until the individual's enrollment in the QHP becomes effective.

29. Family Planning. Family planning services that the QHP considers to be out-of-network, subject to all third party liability rules, will be ensured by the state Medicaid program to be paid at state plan rates.

VI. BENEFITS

30. Iowa Marketplace Choice Plan Benefits. Individuals affected by this demonstration will receive an alternative benefit plan (ABP) described in the Medicaid State plan.

31. Direct Medicaid Benefits. The State will ensure payment under the State plan for ABP benefits that are not covered by QHPs. These benefits include Early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21**.**

32. Access to Direct State Plan Benefits. In addition to receiving an insurance card from the applicable QHP issuer, Marketplace Choice plan beneficiaries will have a Medicaid CIN through which providers may bill Medicaid for direct state plan benefits. The notice containing the CIN will include information about which services Marketplace Choice plan beneficiaries are direct Medicaid benefits and how to access those services. This information will also be posted on Iowa Department of Human Service's Medicaid website and be provided through information at the Department of Human Service's call centers and through QHP issuers.

33. 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.

34. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The State must fulfill its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions) of the Act.

35. Access to Federally Qualified Health Centers and Rural Health Centers. Marketplace Choice plan enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC or RHC.

VIII. HEALTHY BEHAVIORS, PREMIUMS AND COST SHARING

36. Premiums.

a. Authority to charge premiums is subject to the CMS approval of the protocols described in STC 40.
b. No premium will be charged for the first year of enrollment in the Iowa Marketplace Choice Plan.
c. All premiums in this section are subject to the exemptions and waivers described in STC 37.
d. Monthly premium amounts may not exceed $10/month for nonexempt households between 100-133 percent of the FPL.

e. Enrollees will be allowed a 90 day premium grace period.

37. Premium Exemptions. Iowa Marketplace Choice Plan enrollees will be exempt from a monthly contribution obligation under the following conditions:

a. For all individuals enrolled in the Iowa Marketplace Choice 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. 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.

38. 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.

39. Iowa Marketplace Choice Healthy Behaviors. Authority to implement the Healthy Behaviors component is subject to the CMS approval of the protocols described in 40. 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 Marketplace Choice 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.

40. 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.

Premiums

ix) The process by which the state will identify individuals who are exempt from the premium requirements
x) The notices beneficiaries will receive regarding premiums and/or Healthy Behaviors and the schedule for such notices.
xi) The process by which beneficiaries will be able to remit payment, including ways individuals who cannot pay by check will be accommodated.
xii) 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 are 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 disenrolled due to premium non-payment.
v) Individuals with overdue premiums including those with premiums past due less than and greater than 90 days.
vi) Information about the state's collection activities.
vii) Baseline and year 1 data regarding access and utilization.

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.

IX. APPEALS

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.

X. GENERAL REPORTING REQUIREMENTS

41. 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 XII of these STCs.

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

43. 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.

44. 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.

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.

45. 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.

46. 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 44 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;

47. 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.

XI. 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.

48. 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.

49. 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 l0C. 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 sine 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 are not considered here as this program is not eligible.

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

50. 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").

51. 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.

52. 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 44, the actual number of eligible member months for the demonstration populations defined in STC 17. 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.

53. 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.

54. 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.

55. 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.

56. 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.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

57. 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 60, 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.

58. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 60, 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.

59. 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 60 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 62 below.

60. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of demonstration service expenditures 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 - PMPM	DY 2 – PMPM	DY 3 – PMPM
New Adult Group	4.7%	$ 549.65	$ 575.48	$ 602.54

a. 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 1of the demonstration year for which the adjustment would take effect.

b. 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.

c. The State will not be allowed to obtain budget neutrality "savings" from this population.

61. 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.

62. 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.

63. 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%

64. 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.

XIII. EVALUATION

65. Submission of Draft Evaluation Design. The state shall submit a draft evaluation design to CMS no later than 60 days after the award of the demonstration, including, but not limited to data that the state proposes to be used to evaluate healthy behaviors and premiums. CMS shall provide comment within 30 days of receipt from the state. The state must employ aggressive state-level standards for statewide access.

66. 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 and attach to these STCs as Attachment B.

67. Cost-effectiveness. While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the Iowa Marketplace Choice plan Demonstration, which provides premium assistance when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.

a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.

b. Included in the evaluation will be examinations using a robust set of measures of consumer experience, provider access and clinical quality measures under the Marketplace Choice Plan Demonstration compared to what would have happened for a comparable population in Medicaid.

c. The State will compare total costs under the Marketplace Choice Plan Demonstration to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.

d. The State will compare changes in consumer experience, access and quality to associated changes in costs within the Marketplace Choice Plan. To the extent possible, component contributions to changes in consumer experience, access and quality and their associated levels of investment in Iowa will be determined and compared to improvement efforts undertaken in other delivery systems.

68. Evaluation Requirements. The State shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative 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. How the analysis will support a determination of cost effectiveness;
e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
f. The unique contributions and interactions of other initiatives; and
g. 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.

69. 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, reducing churning, 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 analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

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. Premium Assistance beneficiaries will have equal or better access to care than if the population were not required to enroll in a QHP, including primary care and specialty physician networks and services.
ii. Premium Assistance beneficiaries will have equal or better access to preventive care services than if they were not required to enroll in a QHP.
iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services than if they were not required to enroll in a QHP.
iv. Premium Assistance beneficiaries will have fewer gaps in insurance coverage when their eligibility status changes.
v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers, when their eligibility status changes.
vi. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs when their eligibility status changes.
vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions than if they were not required to enroll in a QHP.
viii. Premium assistance beneficiaries will report equal or better satisfaction in the care provided than if they were not required to enroll in a QHP.
ix. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have satisfactory and appropriate access to these benefits.
x. Premium Assistance beneficiaries will have satisfactory access and experience without a non-emergency transportation benefit.
xi. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.
xii. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Iowa Medicaid fee-for-service in accordance with STC 67 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
xiii. Premiums incentivize enrollees to complete healthy behaviors.

xiv. Not assuring non-emergency transportation has no impact on healthy behaviors and does not pose a barrier to access to care.
xv. Enrollees will experience greater access to dental providers.
xvi. The monthly premium does not pose an access to care barrier.
xvii. Marketplace Choice Plan enrollees will use preventative care services at a greater rate than if the demonstration were not in place.

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:

i. Comparisons of provider networks;
ii. Consumer satisfaction and other indicators of consumer experience;
iii. Provider experience ; and
iv. Evidence of improved access and quality across the continuum of coverage and related health outcomes.

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.

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.

70. Interim Evaluation Report. The State is required to submit a draft Interim Evaluation Report 90 days following completion of year two of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 72 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The State shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

71. Summative Evaluation Report. The Summative Evaluation Report will include analysis of data from Year Three of the Premium Assistance Demonstration. The State is required to submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding assessments due to data lags to complete the summative evaluation. Within 360 days of the expiration date of the Premium Assistance Demonstration, the State shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The State should respond to comments and submit the Final Summative Evaluation Report within 30 days.

72. The Final Summative Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.

b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.

f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

73. State Presentations for CMS. The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 69. The State will present on its interim evaluation in conjunction with STC 70. The State will present on its summative evaluation in conjunction with STC 71.

74. Public Access. The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

a. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

75. Electronic Submission of Reports. The State shall submit all required plans and reports using the process stipulated by CMS, if applicable.

76. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of Premium Assistance, 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.

77. Cooperation with Federal Learning Collaboration Efforts. The State will cooperate with improvement and learning collaboration efforts by CMS.

78. 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.

79. Deferral for Failure to Provide Summative Evaluation Reports on Time. The State agrees that when draft and final Interim and Summative 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.

XIV. MONITORING

80. 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 to which premium assistance will apply, 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.

81. 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, including 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.

82. Annual Discussion with CMS. In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

83. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics and network characteristics, 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 premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XV. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

84. 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' 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.