DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

December 30, 2016

Charles Palmer
Director
Iowa Department of Human Services
1305 E. Walnut Street
Des Moines, IA 50319-0114

Dear Mr. Palmer:

The Centers for Medicare & Medicaid Services (CMS) is pleased to inform you that Iowa's request for an extension of its Medicaid section 1115 family planning demonstration, entitled "Iowa Family Planning Network" (IFPN), project number 11-W-00188/7, has been approved. Approval of this demonstration extension is granted under the authority of section 1115(a) of the Social Security Act (the Act) and is effective as of the date of this letter through December 31, 2019.

Under this demonstration, the state will provide family planning services to the following individuals who are not otherwise enrolled in Medicaid (with the exception of Medicaid medically needy with spenddown) and have countable income of no more than 300 percent of the Federal poverty level (FPL):

a) Women losing Medicaid pregnancy coverage at the conclusion of the 60-day postpartum coverage period (also known as "SOBRA pregnant women");
b) Women under the age of 55 who are not pregnant and who are capable of bearing children; and,
c) Men under the age of 55 who are capable of fathering children.

Our approval of this demonstration project is subject to the limitations specified in the approved Special Terms and Conditions (STCs), expenditure authorities, and list of non-applicable title XIX requirements accompanying this award letter. All Medicaid title XIX requirements as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in these approval documents shall apply to the IFPN demonstration. The state's authority to deviate from Medicaid requirements is limited to the specific expenditure authorities and non-applicables described in the enclosed approval documents, and to the purpose(s) indicated.

CMS' approval of this demonstration extension is also conditioned upon the state's compliance with the enclosed STCs defining the nature, character, and extent of federal involvement in this project. This award letter is subject to our receipt of your written acceptance of the award, including the STCs and associated authorities, within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Patricia Hansen, who can be contacted to answer any questions concerning the implementation of this demonstration at (410) 786-4252 or at patricia.hansen1@cms.hhs.gov. Official communications regarding program matters and correspondence concerning the demonstration should be submitted to her at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, MD 21244-1850

Official communications regarding program matters should be submitted simultaneously to Ms. Hansen and to Mr. James Scott, Associate Regional Administrator, in our Kansas City Regional Office. Mr. Scott's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Richard Bolling Federal Building
601 East 12th Street, Room 355
Kansas City, MO 64106-2808

We extend our congratulations to you on this award and look forward to working with you over the course of the demonstration.

Sincerely,

/s/

Vikki Wachino
Director

Enclosures

cc: James Scott, Associate Regional Administrator, CMS Region VII
Sandra Levels, State Representative, CMS Region VII

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: **11 -W-00 188/7**

TITLE: **Iowa Family Planning Network**

AWARDEE: **Iowa Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Iowa for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities, except those specified below as not applicable to these expenditure authorities.

The following expenditure authorities and the provisions specified as "not applicable" enable Iowa to operate this section 1115 Medicaid family planning demonstration through December 31, 2019. CMS is specifically approving expenditure authority to extend Medicaid eligibility for family planning services to the following individuals who are not otherwise enrolled in Medicaid (with the exception of Medicaid medically needy with spenddown) and have countable income of no more than 300 percent of the Federal poverty level (FPL):

a) Women losing Medicaid pregnancy coverage at the conclusion of the 60-day postpartum coverage period (also known as "SOBRA pregnant women");
b) Women under the age of 55 who are not pregnant and who are capable of bearing children; and,
c) Men under the age of 55 who are capable of fathering children.

These expenditure authorities promote the objectives of title XIX in the following ways:

- increases and strengthens overall coverage of low-income individuals in the state; and,
- improves health outcomes for Medicaid and other low-income populations in the state.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Methods of Administration: Transportation **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable the state to not assure transportation to and from

providers for the demonstration population.

2. Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services and family planning-related services.

3. Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics Section 1902(a)(15)

To the extent necessary for the state to establish reimbursement levels to these clinics that will compensate them solely for family planning and family planning-related services.

4. Point-of-Service Eligibility Section 1902(a)(17) and Section 1902(a)(5)

To the extent necessary to enable the state to allow non-state agency staff who are employees or contractors at locations certified as non-state agency provider eligibility determination sites to assist in making determinations of eligibility.

5. Eligibility Procedures Section 1902(a)(17)

To the extent necessary to allow the state to not require reporting of changes for income or household size for 12 months, for a person found income-eligible upon application or annual redetermination when determining eligibility for the demonstration.

6. Retroactive Coverage Section 1902(a)(34)

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section 1902(a)(43)(A)

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration population.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: **11 -W-00188/7**

TITLE: **Iowa Family Planning Network**

AWARDEE: **Iowa Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Iowa's section 1115(a) Medicaid family planning demonstration entitled the, "Iowa Family Planning Network (IFPN)." The parties to this agreement are the Iowa Department of Human Services and the Centers for Medicare & Medicaid Services (CMS). The 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. These STCs are effective through December 31, 2019. All previous CMS-approved STCs, waivers, expenditure authorities, and/or non-applicable title XIX requirements are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

Effective through December 31, 2019, the IFPN section 1115(a) Medicaid demonstration expands the provision of family planning services to the following individuals who are not otherwise enrolled in Medicaid (with the exception of Medicaid medically needy with spenddown) and have countable income of no more than 300 percent of the Federal poverty level (FPL):

a) Women losing Medicaid pregnancy coverage at the conclusion of the 60-day postpartum coverage period (also known as "SOBRA pregnant women");
b) Women under the age of 55 who are not pregnant and who are capable of bearing children; and,
c) Men under the age of 55 who are capable of fathering children.

Historical Context and Objectives

On January 10, 2006, CMS originally approved this Medicaid section 1115(a) demonstration proposal entitled "Iowa Family Planning Network (IFPN)," which the state implemented on February 1, 2006, to cover limited family planning and family planning-related services for women who were not otherwise enrolled in Medicaid, the Children's Health Insurance Program (CHIP), or in other health insurance coverage and: (1) had countable income at or below 200 percent of the Federal Poverty level (FPL); or (2) had lost Medicaid pregnancy coverage at the conclusion of the 60-day postpartum period. On December 15, 2011, CMS approved several program changes requested by Iowa that increased the income limits, added coverage for men, and eliminated the requirement that individuals must not have health insurance coverage for family planning services or be enrolled in Iowa's CHIP program.

Effective January 1, 2014, the IFPN Medicaid demonstration expanded family planning and family planning-related services to individuals aged 12-54, not otherwise enrolled in Medicaid and were: (1) women losing Medicaid pregnancy coverage at the conclusion of their 60-day postpartum coverage period with family income at or below 300 percent of the FPL, or (2) men and women with family income at or below 300 percent of the FPL.

On June 30, 2016, Iowa submitted an extension application to continue the demonstration for three additional years with no significant program changes. CMS is approving the state's requested demonstration extension for the period of January 1, 2017 through December 31, 2019.

IFPN operates on a state-wide basis through a partnership with family planning clinics that are certified to participate in the Medicaid program. Designated family planning clinic staff act as external assistors to process IFPN eligibility for men and women. Family planning clinic staff assists in the application process. Clinic staff obtain the information needed to determine eligibility and provide information to applicants on how to access primary care services through face-to-face conversation, telephone conversation or by mail.

Applications may be filed at a Department of Human Services (DHS) office, any facility where out-stationing activities are provided, with the third-party administrator (TPA) for Iowa's CHIP program (called "hawk-I"), with presumptive Medicaid providers, at WIC offices, or at maternal or child health centers. Applications may also be filed at designated family planning agencies and satellite clinics across the state.

For women with Medicaid pregnancy coverage nearing the end of the 60-day post-partum coverage period, enrollment is accomplished through an automated process that does not require an application and is triggered by payment of a claim in the state's Medicaid Management Information System (MMIS) for a service that indicates that the pregnancy cycle has been completed.

CMS and Iowa expect this demonstration program will promote Medicaid program objectives by:

- Improving access to and use of Medicaid family planning services by women who have received Medicaid pregnancy-related services;
- Improving birth outcomes and the health of women by increasing the child spacing interval among women in the target population;
- Decreasing the number of Medicaid paid deliveries, which will result in a reduction of annual expenditures for prenatal, delivery newborn and infant care;
- Reducing the number of unintended and unwanted pregnancies among women eligible for Medicaid; and,
- Reducing teenage pregnancy by reducing the number of repeat teenage births.

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 Law, Regulation, and Policy.** All requirements of the Medicaid programs 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), must apply to the demonstration .

3. **Changes in Medicaid 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 program that occurs during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.

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

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 for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

b) If mandated changes in 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. **Changes Subject to the Amendment Process.** Changes related to demonstration features such as eligibility, enrollment, benefits, 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 Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. 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 6 below. The state will notify CMS of proposed demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

6. **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 therein. 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 14 to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit;

   c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and,

   d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration**. No later than twelve (12) months prior to the expiration date of the demonstration, the Governor of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal

Regulations (CFR) §431.412(c) or a phase-out plan consistent with the requirements of STC 8.

8. Demonstration Phase-Out. The state may suspend or terminate this demonstration in whole, or in part, at any time prior to the date of expiration.

a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination. At least six (6) months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a thirty (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 thirty (30) day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the received comments into the transition and phase-out plan submitted to CMS.

b) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out 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 and community resources that are available.

c) Phase-out Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of phase-out activities. Implementation of phase-out activities must be no sooner than fourteen (14) days after CMS approval of the phase-out plan.

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 as found in 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 titles XIX or XXI would be served or under circumstances described in 42 CFR §431.416(g).

f) Enrollment Limitation during Demonstration Phase-Out: If the state elects to suspend, terminate, or not extend this demonstration, during the last six (6) months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g) 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 participants.

9. **CMS Right to Amend, Terminate or Suspend.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

10. **Deferral of Payment for Failure to Provide Deliverables on Time.** CMS will withhold payments to the state in the amount of $1,000,000 per occurrence when deliverables are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS.

a) Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b) For each deliverable, the state may submit a written request for an extension in which to submit the required deliverable. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c) The deferral would be issued against the next quarterly expenditure report following the written deferral notification (subject to any extension granted under (b)).

d) When the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in the STCs, the deferral(s) will be released.

e) As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for extension, amendment or renewal, or for a new demonstration.

f) If applicable, CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example, the structure of the state request for an extension, what quarter the deferral applies to and how the deferral is released.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to 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 must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and must 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, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

13. **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 applicable to the demonstration; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other demonstration components.

14. **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 §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6 are proposed by the state.

    a) *Consultation with Federally Recognized Tribes on New Demonstration Proposals Applications and Renewals of Existing Demonstrations*. In states with Federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 State Medicaid Directors letter (SMDL #01-024) 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 §431.408(b)(2)).

    b) *Seeking Advice and Guidance from Indian Health Programs Demonstration Proposals, Renewals, and Amendments*. In states with 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 in accordance with the process in the state's approved Medicaid state plan prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.

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

IV. ELIGIBILITY AND ENROLLMENT

16. Modified Adjusted Gross Income (MAGI) Based Methodologies and Streamlined Application Process. The state must conduct eligibility determinations and implement enrollment requirements in accordance with section 1943 of the Act (and implementing federal regulations at 42 CFR part 435) except that Iowa may continue to target eligibility for this demonstration to those individuals described in STC 17.

Iowa must implement all modified adjusted gross income-based methodologies described in regulations at 42 CFR part 435 when conducting eligibility determinations for and enrollment into the IFPN demonstration. To the extent that Iowa is not currently in compliance with such methodologies, Iowa must implement a CMS–approved plan to achieve compliance (a "mitigation plan") in IFPN with all eligibility and enrollment requirements. By no later than June 30, 2017, the state's mitigation plan must include a detailed description of milestones the state will complete every six (6) months to progress towards full compliance with all applicable eligibility and enrollment requirements for IFPN by no later than July 31, 2019. This timeline reflects the integration of IFPN eligibility processes with eligibility processes used under the state plan. Iowa's mitigation plan must include strategies the state will adopt to address issues with operational capabilities and systems functionality that are delaying the state from being able to meet applicable requirements in key focus areas critical to fulfilling the requirements at 42 CFR part 435. As discussed with the state, the key focus areas applicable to the IFPN demonstration that Iowa must prioritize are as follows:

i. Ability to convert existing state income standards to MAGI.
ii. Ability to process applications and use the MAGI-based methodology to determine financial eligibility. When delegating authority for eligibility determinations, the state will comply with all of the requirements and limitations set forth in 42 CFR §431.10 and 42 CFR §431.11. The state may not deny coverage under this demonstration unless the applicant has had a complete MAGI-based eligibility determination and found to be ineligible for the IFPN demonstration based on MAGI rules.
iii. Ability to verify eligibility based on electronic data sources (the Federal Data Services Hub or an approved alternative) as described in the state's verification plan.
iv. Ability to conduct an ex parte renewal process and provide pre-populated renewal forms to individuals whose eligibility cannot be redetermined based on available information.
v. Ability to implement a family planning-specific application that includes all information needed to determine eligibility based on MAGI.

The strategies identified in Iowa's mitigation plan must include an associated timeline, with a

deliverable the state can implement every six (6) months from the date CMS approves the state's mitigation plan through July 31, 2019 when the state will be in full compliance. The state will be subject to the CMS deferral process described in STC 10 for each six (6) month deliverable the state fails to meet on time. Once CMS approved, Iowa must submit any proposed change to the mitigation plan in writing and the change will not be effective until agreed upon by both parties in writing.

17. **Eligibility Requirements.** Family planning services and family planning related services are provided to eligible individuals for twelve (12) months of continuous eligibility. An individual found to be income-eligible for this demonstration upon initial application or annual redetermination will not require reporting of changes in income or household size for this twelve (12) month period.

    Effective through December 31, 2019, eligibility for this demonstration is limited to the following individuals who are not otherwise enrolled in Medicaid (with the exception of Medicaid medically needy with spenddown) and have countable income of no more than 300 percent of the FPL:

    a) Women losing Medicaid pregnancy coverageat the conclusion of the 60-day postpartum coverage period (also known as "SOBRA pregnant women");
    b) Women under the age of 55 who are not pregnant and who are capable of bearing children; and,
    c) Men under the age of 55 who are capable of fathering children.

18. **Point-of-Service Eligibility.** Iowa may use a point-of-service eligibility process in order to facilitate streamlined access to eligibility determinations, with the ultimate goal of expanded access to family planning and family planning-related care. Designated family planning agencies and providers assist the state in processing and the determination of eligibility for the demonstration. The state's family planning rules-based system determines eligibility for the demonstration. Family planning staff at the designated agencies and providers sites may have the following responsibilities including, but not limited to assisting in collecting, reviewing, and recording of eligibility information into the rules-based system. Additionally, the family planning staff may assist in communicating eligibility decisions to the applicant and the oversight of ongoing case management. Family planning staff may not perform functions that require discretion related to eligibility determinations. The state utilizes a Memorandum of Understanding (MOU) with each designated family planning agency and provider. The MOU ensures adherence with Medicaid provisions including, but not limited to standard procedures and processes; confidentiality; and the scope of work itself.

19. **Redeterminations.** The state will complete redeterminations of eligibility for the demonstration at least every twelve (12) months. At the state's option, redeterminations may be administrative in nature.

20. **Demonstration Disenrollment.** If a woman becomes pregnant while enrolled in the demonstration, she may be determined eligible for Medicaid under the State Plan. The state

must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State Plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will subsequently be disenrolled from this demonstration.

V. BENEFITS AND DELIVERY SYSTEMS

21. Family Planning Benefits. Individuals eligible under this demonstration will receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act, which are reimbursable at the enhanced ninety (90) percent Federal matching rate. The specific family planning services provided under this demonstration are as follows:

a) FDA-approved methods of contraception;

b) Laboratory tests done during an initial family planning visit for contraception, including Pap smears, screening tests for STIs/STDs, blood counts and pregnancy tests. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception;

c) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements;

d) Contraceptive management, patient education, and counseling.

22. Family Planning-Related Benefits. Individuals eligible under this demonstration will also receive family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:

a) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.

b) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.

c) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital

skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.

d) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

e) Treatment of major complications arising from a family planning procedure such as:
   i. Treatment of a perforated uterus due to an intrauterine device insertion;
   ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
   iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

23. Minimum Essential Coverage (MEC). The IFPN demonstration is limited to the provision of family planning services as described in STC 21 and 22; thereby, the demonstration is not recognized as MEC as communicated by CMS in its February 12, 2016 correspondence from Vikki Wachino to Mikki Stier, Medicaid Director, regarding the designation of MEC for the state's section 1115 demonstrations.

24. Primary Care Referrals. Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.

25. Delivery of Services. Enrollees in the IFPN demonstration will receive services through a managed care delivery system consistent with the approved section 1915(b) waiver; otherwise, services will be provided on a fee for service basis. Beneficiary freedom of choice of family planning provider shall not be restricted.

VI. GENERAL REPORTING REQUIREMENTS

26. General Financial Requirements. The state must comply with all general financial requirements under title XIX set forth in section VII.

27. Reporting Requirements Relating to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII.

28. Monitoring Calls. CMS and the state will participate in quarterly conference calls following the receipt of the quarterly reports, unless CMS determines that more frequent calls are necessary to adequately monitor the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care,

access, benefits, anticipated or proposed changes in payment rates, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, state legislative developments, and any demonstration amendments the state is considering submitting. The state and CMS will discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS will update the state on any amendments 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.

29. Quarterly Operational Reports. The state must submit quarterly operation reports for the first three quarters in a DY. The fourth quarter report should be submitted as part of the annual report. The state must submit progress reports no later than sixty (60) days following the end of each quarter for every demonstration year (DY) using the format outlined in Attachment A. The state must submit the quarterly report through CMS' designated system. The intent of these reports is to present the state's data along with an analysis of the status of the various operational areas under the demonstration. The Quarterly Report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section. These quarterly reports must include, but are not limited to:

a) A summary of current notable program activity. This includes highlights of activity occurring during the quarter, or anticipated to occur in the near future, pertaining to provider participation, health care delivery, benefits, eligibility, enrollment, beneficiary complaints, grievances, and/or appeals, quality of care, access, payment rates, pertinent legislative activity, and other operational issues;

b) Quarterly enrollment and member month counts (per STC 37) for demonstration enrollees (defined as any individual who obtains a covered family planning service through the demonstration) as required to evaluate compliance with the budget neutral agreement;

c) Notification of any changes in enrollment and/or participation that fluctuate ten (10) percent or more in relation to the previous quarter; and,

d) Quarterly expenditures for the demonstration population as reported on the CMS-64 (per STC 33) as required to evaluate compliance with the budget neutral agreement;

30. Annual Report. The state must submit annual reports that, at a minimum, include the requirements outlined below using the format outlined in Attachment A. The state's fourth quarter progress report for each demonstration year (DY) may serve as the state's annual report. The state must submit the annual report through CMS' designated system. The fourth quarter/annual report shall include an end of year summary of the program elements as reported in each quarterly report for the DY. The annual report is due ninety (90) days following the end of the fourth quarter of each DY. The annual report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section

a) All program items included in the quarterly report pursuant to STC 29 must be summarized to reflect activities throughout the DY;

b) Total annual expenditures for the demonstration population;

c) Total annual member month count for demonstration enrollees as required to evaluate compliance with the budget neutral agreement as specified in STC 43;

d) Annual budget neutrality target calculation;

e) Annual enrollment counts for the demonstration population by race/ethnicity;

f) Annual disenrollment/retention figures;

g) Summary of program outreach activities that occurred during the DY;

h) Summary of program evaluation activities and any interim evaluation findings;

i) End-of-year report on the utilization of contraceptive methods dispensed during the DY and percentage of usage by women between ages 15-44;

j) A summary of the annual post award public forum conducted by the state as required by 42 CFR §431.420(c) and,

k) Summary of program integrity and related audit activities for the demonstration.

31. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration. The state must confirm its process for ensuring there is no duplication of federal funding in each annual report as specified in STC 30(k).

32. Final Demonstration Report. The state must submit a final demonstration report to CMS to describe the impact of the demonstration, including the extent to which the state met the goals of the demonstration. The draft report will be due to CMS 120 days after the expiration of the demonstration. CMS must provide comments within sixty (60) days of receipt of the draft final demonstration report. The state must submit a final demonstration report within sixty (60) days of receipt of CMS comments.

VII. 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.

33. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports to report total expenditures for services provided under this Medicaid section 1115(a) demonstration following routine CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined cost limits specified in STC 43.

34. Reporting Expenditures Subject to the title XIX Budget Neutrality Agreement. The following describes the reporting of expenditures subject to the budget neutrality limit:

a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES). All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure 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.

b) Use of Waiver Forms. The state must report demonstration expenditures on separate forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report title XIX expenditures for demonstration services. The state will use the waiver name "Family Planning Dem." to report expenditures in theMBES/CBES system.

c) Cost Settlements. For monitoring purposes, 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.

35. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on Form CMS-64.10.

36. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two (2) years after the conclusion or termination of the demonstration. During the latter two (2) year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

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

a) For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the quarterly and annual reports as required under STC 29 and 30 respectively, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the quarterly and annual reports, certifying the accuracy of this information.

b) The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration 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 (2) months, each contribute two eligible member months, for a total of four eligible member months.

38. 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 limit and separately report these expenditures by quarter for each federal fiscal year on Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. Subject to the payment deferral process set out in STC 10, CMS shall reconcile expenditures reported on Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

39. Extent of Federal Financial Participation (FFP) for the Demonstration. CMS shall provide FFP for family planning and family planning-related services at the applicable federal matching rates as described in STCs 21 and 22, subject to the limits and processes described below:

a) For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management, and sterilizations), and which are provided in a family planning setting, FFP will be available at the ninety (90) percent federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate of ninety (90) percent, as described in STC 21, should be entered in Column (D) on the CMS-64.9 Waiver Form.

b) Pursuant to 42 CFR §433.15(b)(2), FFP is available at the ninety (90) percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering,

arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the fifty (50) percent administrative match rate.

c) In order for family planning-related services to be reimbursed at the FMAP rate they must be defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a "family planning-related" problem was identified/diagnosed during a routine/periodic family planning visit. These expenditures should be entered in Column (B) on the appropriate CMS-64.9 Waiver Form.

d) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the ninety (90) percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

40. Sources of Non-Federal Share. The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to 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 shall 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 must be addressed within the time frames set by CMS.

b) Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

41. 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 one-hundred (100) percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and 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, 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.

VIII. MONITORING BUDGET NEUTRALITY

The following is the method by which budget neutrality will be monitored for the Iowa IFPN section 1115(a) Medicaid demonstration.

42. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding it may receive on approved demonstration service expenditures incurred during the period of demonstration approval. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the approved demonstration period. Actual expenditures subject to budget neutrality expenditure limit shall be reported by the state using the procedures described in STC 34.

43. Budget Neutrality Annual Expenditure Limits. For each DY, an annual budget limit will be calculated for the demonstration. This program's annual demonstration cycle is calendar year (i.e., January 1 - December 31). The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share.

PMPM Cost. The following table provides the approved demonstration cost trend (based on the state's historical rate of growth) and the PMPM (total computable) ceiling for each DY.

	Trend	**DY 12 (CY2017)**	**DY 13 (CY2018)**	**DY 14 (CY 2019)**
Demonstration	.0%	$35.86	$35.86	$35.86

PMPM Ceilings				

a) Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the forms listed in STC 30 above, 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 approval period (see STCs 8 and 9), 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 Composite Federal Share may be used.

b) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures reported by the state on the CMS-64 forms. If at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess federal funds will be returned to CMS. If the costs of the demonstration services do not exceed the budget limit, the state may not derive or utilize any such savings.

44. 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.

45. Enforcement of Budget Neutrality. CMS will enforce budget neutrality over the life of this demonstration approval period. However, no later than six (6) months after the end of each DY or as soon thereafter as the data are available, the state will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the state exceeds these targets, it will submit a corrective action plan to CMS for approval as outlined in STC 46.

Demo Year	Cumulative Target Definition	Percentage
DY 12 (CY 2017)	DY 12 budget limit amount plus:	1.0 percent
DY 13 (CY 2018)	DY 12 and DY 13 combined budget limit amount plus:	0.5 percent
DY 14 (CY 2019)	DYs 12 through 14 combined budget limit amount plus:	0 percent

46. Budget Neutrality Corrective Actions. The state, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which must include submitting a corrective action plan to CMS within twenty-one (21) days of the date the state is informed of the problem. While CMS will pursue corrective actions with the

state, CMS will work with the state to set reasonable goals that will ensure that the state is in compliance.

IX. EVALUATION

47. Submission of an Updated Draft Evaluation Design. In the 120 days following the date of approval of this demonstration extension, the state shall submit an updated evaluation design that identifies and discusses the demonstration outcome measures for testing the below hypothesis the state intends to evaluate over the demonstration extension period:

a) Improve the access to and use of Medicaid family planning services by women who have received a Medicaid pregnancy related service;
b) Improve birth outcomes and the health of women by lengthening the childbirth interval among women in the target population;
c) Decrease the number of Medicaid paid deliveries, which will reduce annual expenditures for prenatal, delivery newborn and infant care;
d) Reduce the number of unintended pregnancies among women eligible for Medicaid.
e) Reduce teen pregnancy by reducing the number of repeat teen births; and,
f) Estimate the overall savings in Medicaid spending attributable to providing family planning services to women for one year postpartum.

The proposed demonstration evaluation design that will formulate the final evaluation plan described in STC 49 will meet the prevailing standards of scientific evaluation and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. When developing the evaluation design, the state shall consider ways to structure the design that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the research hypotheses. For each research hypothesis, the state must identify a preferred quantitative and/or qualitative research methodology and provide a rationale for its selected methodology. To the extent applicable, the following items must be specified for each design option considered:

a) Identification of independent evaluator
b) Quantitative or qualitative outcome measures;
c) Identification of study design and population;
d) Proposed baseline and/or control comparisons;
e) Proposed process and improvement outcome measures and specifications;
f) Data sources, collection frequency; and proposed analyses;
g) Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
h) Timelines for deliverables; and,
i) The total estimated cost for the evaluation, 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.

The evaluation design must include all required elements and should not direct readers to links outside the report, except if listed in a reference/bibliography section.

48. Evaluation Design Approval and Final Evaluation Plan. CMS shall provide comments on the proposed evaluation design within sixty (60) days of receipt, and the state must submit a final plan for the overall evaluation of the demonstration within sixty (60) days of receipt of CMS comments. The state's proposed evaluation design may be subject to multiple revisions until a format is agreed upon by CMS. Upon CMS approval of the final evaluation design, the document will be included as Attachment B to these STCs. Per 42 CFR §431.424(c), the state will publish the approved evaluation design within 30 days of CMS approval. The state must implement the evaluation design and report on their evaluation implementation progress in the annual report as required by STC 30(h).

Post CMS approval, should the state choose to change the evaluation design (such as changes to research hypotheses, objectives, or research methodologies), it must submit an amendment request as set forth in STC 6.

49. Interim Evaluation Report. The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration as required by 42 CFR §431.412(c)(2)(vi). The interim evaluation report will discuss evaluation progress and present findings to date based on the approved evaluation plan. The interim evaluation report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section.

50. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by CMS; including submission of any required data to CMS or its contractor.

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

52. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the final evaluation design, the state's interim evaluation, and/or the summative evaluation report.

53. Summative Evaluation Report. The state must submit to CMS a draft of the summative evaluation report within eighteen (18) months following the end of the approval period represented in these STCs. The summative evaluation report shall include items as required in the approved evaluation design. The state will present to and participate in a discussion with CMS on the interim and final evaluations. The state must take into consideration CMS' comments for incorporation into the final report. The final summative evaluation report is due to CMS no later than sixty (60) days after receipt of CMS' comments. The final

summative evaluation report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Mitigation Plan	By no later than June 30, 2017	STC 16
Quarterly Report	Within 60 days following the end of each demonstration quarter	STC 29
Annual Report	Within 90 days following the end of the 4th quarter for each DY	STC 30
Draft Evaluation Design	Within 120 days after the approval of the demonstration extension	STC 47
Final Evaluation Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 48
Summative Evaluation Report	Within 18 months following the end of this demonstration extension period	STC 53

ATTACHMENT A: Template for Quarterly and Annual Operational Reports

Iowa Family Planning Network
Section 1115 Quarterly Report
Demonstration Year X, Quarter X
Federal Fiscal Quarter X
Date Submitted

Introduction

Provide a brief historical background and overview of the demonstration (e.g., populations served, benefits provided, overall goals/objectives of the demonstration, etc.).

Executive Summary

- *Current Trends or Significant Program Changes*
  - Narrative describing any administrative and operational changes to the demonstration, such as eligibility and enrollment processes, eligibility redetermination processes (including the option to utilize administrative redetermination), systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes).
  - Narrative on any noteworthy demonstration changes, such as changes in enrollment, service utilization, and provider participation. Discussion of any action plan if applicable.

- *Policy Issues and Challenges*
  - Narrative of any operational challenges or issues the state has experienced.
  - Narrative of any policy issues the state is considering, including pertinent legislative/budget activity and potential demonstration amendments.
  - Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable.

Enrollment

- Include a narrative of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter.

- Please utilize the chart below to provide data on the number of individuals enrolled in the demonstration as of the end of the quarter and associated eligible member months (as defined in STC 37).

	Quarter 1 (fill in quarter dates)	**Quarter 2 (fill in quarter dates)**	**Quarter 3 (fill in quarter dates)**	**Quarter 4 (fill in quarter dates)**
# of Total Enrollees				
# of Member Months				

Service Providers

- Provide a narrative on current provider participation; highlighting any current or expected changes in provider participation, planned eligibility provider outreach and the implication for health care delivery.

Program Monitoring

- Identify any quality monitoring activities in current quarter.

- Provide a narrative of any feedback and grievances made by beneficiaries, providers, or the public; including any public hearings or other notice procedures, with a summary of the state's response or planned response.

Expenditures

- As outlined in Section VII of these STCs, the state is required to provide quarterly expenditure reports using the Form CMS-64 to report expenditures for services provided under the demonstration. Please also include those CMS-64 reported expenditures in the chart below.

Demonstration Year XX [fill in start & end dates]	**Service Expenditures as Reported on the CMS-64 (Total Computable)**
Quarter 1 - CMS 64 Service Expenditures	
Quarter 2 - CMS 64 Service Expenditures	
Quarter 3 - CMS 64 Service Expenditures	
Quarter 4 - CMS 64 Service Expenditures	
Total DY Annual Expenditures	

Activities for Next Quarter

- Report on any anticipated activities for next quarter.

Additional Information to Provide in Fourth Quarter/Annual Reports:

In addition to the information outlined above for quarterly reports, the state's fourth quarter/end-of-year report shall also include information on the below program elements:

Expenditures

- End-of-year calculation of total quarterly expenditures claimed for the demonstration year and a comparison against the budget neutrality target outlined in STC 45. The state

will also provide a narrative on any budget neutrality issues the state has identified. If the state has exceeded the defined cumulative target for the demonstration year, please include a description of the state's intended corrective action plan.

Enrollment

- Annual enrollment for the demonstration year and end-of year enrollment for the most recent five (5) years of the demonstration (including the current demonstration year). Provide narrative on any observed trends and explanation of data.
- Annual enrollment by race/ethnicity for the current demonstration year.
- Annual disenrollment and Retention figures
    - Discuss the current demonstration year's retention and disenrollment figures; including top reasons for disenrollment, trends observed throughout the demonstration year, and comparison to previous demonstration years.

Program Outreach and Education

- *General Outreach and Awareness*
    - Provide information on the public outreach and education activities conducted this demonstration year; and,
    - Provide a brief assessment on the effectiveness of these outreach and education activities.
- *Target Outreach Campaign(s) (if applicable)*
    - Provide a narrative on the populations targeted for outreach and education campaigns and reasons for targeting; and,
    - Provide a brief assessment on the effectiveness of these targeted outreach and education activities.

Program Evaluation and Monitoring

- Identify an overall summary of quality assurance and monitoring activities conducted in the demonstration year; including a discussion of program evaluation activities, how the state is progressing on meeting its stated goals/performance targets, and any interim evaluation findings.
- Provide a summary of the annual post award public forum conducted by the state as required by 42 CFR §431.420(c) that includes a report of any issues raised by the public and how the state is considering such comments in its continued operation of the demonstration.
- Provide a summary of any program integrity and related audit activities for the demonstration that occurred in the demonstration year.

Contraceptive Methods

- Using the below chart, indicate the *number of each contraceptive method dispensed* in the demonstration year. If the state did not receive any claims for a specific contraceptive method in the current year, enter a zero ("0"). If the state does not cover a specific method under its demonstration, enter not applicable ("N/A"). The *number of unique contraceptive users* should identify the number of unique beneficiaries who received a given method in the demonstration year. The *data source* column should

specify the type of data used to describe the specified contraceptive method (i.e., MMIS data, claims data, chart review, etc.).

Iowa Family Planning Demonstration – Contraceptive Methods			
Demonstration Year X (mm/dd/yy – mm/dd/yy)			
	Number of contraceptive method dispensed	Number of unique contraceptive users	Data source
Male Condom			
Female Condom			
Sponge			
Diaphragm			
Pill			
Patch			
Ring			
Injectable			
Implant			
IUD			
Emergency Contraception			
Sterilization			

- Using the below chart, provide information on the CMS measure "Contraceptive Utilization by Women." This measure assesses the percentage of women ages 15–44 that:
    - Adopted or continued use of the most effective or moderately effective FDA-approved methods of contraception.
    - Adopted or continued use of a long-acting reversible method of contraception (LARC).

  Two rates are reported for each measure, one for ages 15–20 and one for ages 21–44. Specifications may be found on CMS' Maternal and Infant Health Care Quality page, under the "Data and Measurement" tab. See webpage at: (https://www.medicaid.gov/medicaid chip-program-information/by-topics/quality-of-care/maternal-and-infant-health-care quality.html).

	Ages 15-20			Ages 21-44		
	Rate	Numerator	Denominator	Rate	Numerator	Denominator
Most and Moderately Effective Methods						
LARC Methods						

ATTACHMENT B: Evaluation Design

(reserved)

The state will continue to test the below hypothesis to evaluate demonstration performance:

a) Improve the access to and use of Medicaid family planning services by women who have received a Medicaid pregnancy related service.

b) Improve birth outcomes and the health of women by lengthening the childbirth interval among women in the target population.

c) Decrease the number of Medicaid paid deliveries, which will reduce annual expenditures for prenatal, delivery newborn and infant care.

d) Reduce the number of unintended pregnancies among women eligible for Medicaid.

e) Reduce teen pregnancy by reducing the number of repeat teen births.

f) Estimate the overall savings in Medicaid spending attributable to providing family planning services to women for one year postpartum.

CMS and the state will work together to develop specific outcome measures for this demonstration extension period as outlined in STCs 47 and 48 that reflect the current healthcare landscape and goals of the program.