**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS**
**Revised January 10, 2013**

**NUMBER:** 11-W-00189/7

**TITLE:** IowaCare

**AWARDEE:** Iowa Department of Human Services

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Iowa's IowaCare section 1115(a) Medicaid Demonstration (hereinafter referred to as "Demonstration"). The parties to this agreement are the Iowa Department of Human Services (State) 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. The amended STCs are effective January 10, 2013, unless otherwise specified. This Demonstration is approved through December 31, 2013.

The amended STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility Determination, Enrollment, and Disenrollment
V. Benefits
VI. Cost Sharing
VII. Delivery Systems
VIII. General Reporting Requirements
IX. General Financial Requirements
X. Monitoring Budget Neutrality for the Demonstration
XI. Benchmarks
XII. Evaluation
XIII. Schedule of State Deliverables During the Demonstration

## II. PROGRAM DESCRIPTION AND OBJECTIVES

The IowaCare Demonstration was originally approved and began implementation on July 1, 2005. Under this renewal, the State will continue to provide health care services to the Expansion Population and Spend-down Pregnant Women populations. During the renewal period, children with serious emotional disorders will be served under a 1915(c) home and community-based services waiver.

Under this Demonstration extension, Iowa expects to achieve the following to promote the objectives of title XIX:

- Access: Improve access to and coordination of the most appropriate cost effective care through implementation of a medical home pilot.

- Quality: Encourage provision of quality medical services to all enrollees. Encourage quality, continuity, and appropriate medical care.

  Improve the health status of IowaCare enrollees by improving access to a greater number of beneficiaries by adding additional network providers in underserved areas of the State.

- Prevention: Encourage individuals to stay healthy and seek preventive care through care coordination in the medical home pilot.

On November 1, 2011, the state of Iowa was approved to implement an uncompensated care pool (IowaCare Safety Net Care Pool or I-SNCP). The purpose of the I-SNCP is to reimburse expenditures incurred by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services provided to IowaCare members. Allowable expenditures include durable medical equipment and outpatient prescription drugs provided to IowaCare members assigned to Broadlawns as a medical home (above the current 10-day supply of prescription medication after an inpatient hospitalization available to all IowaCare members); durable medical equipment, in-home health care and rehabilitation and therapy services after an inpatient stay; and costs borne by FQHCs for IowaCare members using the FQHC as a medical home when the FQHCs do not have the needed laboratory or radiology services on site.

## 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 program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the 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 time frames specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy statement affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly identified as not applicable.

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 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 State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required, except as otherwise noted in these STCs.

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. 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 section III, paragraph 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 section III, paragraph 13, 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 agreement. Such analysis shall include current 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 detailed 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. 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 will be modified to incorporate the amendment provisions.

8. **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 phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft 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 phase-out plan.

    The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

    b. 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.

    c. 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 discussed in the October 1, 2010, State Health Official Letter #10-008.

    d. 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 Terminate or Suspend.** CMS may 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 suspension or termination, together with the effective date.

10. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

11. **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 will promptly notify the State in writing of the determination and the reasons for the 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, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

12. **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.

13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in section III, paragraph 7, are proposed by the State. 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.

14. **FFP.** No Federal matching for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

## IV. ELIGIBILITY DETERMINATION, ENROLLMENT, and DISENROLLMENT

15. **Demonstration Populations.** The populations described in Table 1 are eligible for the Demonstration. Only persons who do not meet the eligibility requirements of the Medicaid State plan are eligible for the Demonstration. Demonstration Eligibles will be assigned to the designated medical home as defined in paragraph 27.

**Table 1**

| Population Name | Population Description | Federal Poverty Level (FPL) or other criteria | Expenditure and Eligibility Group Reporting |
|---|---|---|---|
| Demonstration Population 1 | Custodial parents and caretaker relatives who are not otherwise eligible for Medicaid or Medicare | Family income up to 200 percent of the FPL; no resource limit | Expansion Pop. |
| | Non-custodial parents and | 0% FPL through 200% FPL; no | |

| | | | |
|---|---|---|---|
| | childless adults (age 19 – 64) who are not otherwise eligible for Medicaid or Medicare | resource limit | |
| Demonstration Population 2 | Spend-down Pregnant Women | Less than or equal to 300% of the FPL who have incurred medical expenses for all family members that reduce available family income to 200% of the FPL, with resources in excess of Medicaid State plan limits | Spnd-dwn Preg. Wmn. |

16. **Enrollment Cap**. Any numeric enrollment limitation must be submitted to CMS for review and approval following the process outlined in section III, paragraph 7.

17. **Eligibility Exclusions.** Generally, a person who has access to group health insurance is not eligible for IowaCare. However, a person with access to group health insurance may enroll in IowaCare, if the individual states that any of the following conditions exist:
    a. The coverage is unaffordable;
    b. Exclusions for preexisting conditions apply;
    c. Needed services are not services covered by the plan;
    d. The limits of benefits under the plan have been reached; or,
    e. The plan includes only catastrophic health care coverage.

18. **Enrollment.** The enrollment process is as follows:
    a. Applicant files an application at a local department office or Disproportionate Share Hospital, Federally Qualified Health Center (FQHC), resource center or other facility where out-stationing activities are provided.
    b. Applicant may request one retroactive month of eligibility.
    c. The State makes the eligibility determination.
    d. At the end of the eleventh month, the IowaCare renewal application is sent to the applicant.
    e. Individuals enrolled in IowaCare must have an eligibility redetermination at least once every 12 months. Each redetermination must include a reassessment of the individual's eligibility for Medicaid. An IowaCare member may apply for Medicaid at any time for any reason. The State will determine eligibility and enroll individuals in programs for which they are found eligible.

19. **Disenrollment.** Members are disenrolled for the following reasons:
    a. The 12-month certification period ends;
    b. The member is determined eligible for Medicaid or Medicare;
    c. The member does not pay the premium or request hardship timely. Members shall have a 60 day grace period (from the date the premium is due) to pay their premium. Members must request a hardship by the due date;
    d. The member no longer meets the nonfinancial eligibility requirements;
    e. The member was determined eligible due to member misrepresentation or agency error;
    f. The member requests cancellation;
    g. The member moves out of State; or,
    h. The member dies.

20. If an IowaCare member is disenrolled for failing to pay the premium or requesting hardship, the member may owe an outstanding obligation to the State. However, the individual must be allowed to reenroll in the Demonstration (assuming the individual continues to meet eligibility requirements) and continue to have the option of claiming hardship.

## V. BENEFITS

21. **Benefits.** The benefits and coverage are limited to inpatient hospital, outpatient hospital, physician, advanced registered nurse practitioner, and a limited dental benefit. Pharmacy and durable medical equipment and supplies that are prescribed or provided as part of a covered inpatient hospital stay are also covered services. IowaCare members may receive a 10-day supply of prescription medication to take home after an inpatient hospital discharge. All conditions of service provision will apply in the same manner as under the Medicaid State plan, including, but not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be medically necessary.

    IowaCare members will also have access to smoking cessation medication and counseling and a nurse helpline.

    Demonstration Population 2 (Spend-down Pregnant Women) will also receive obstetric services.

    A description of the benefits also appears in Table 2 below:

| Benefit | Notes/ Limitations |
|---|---|
| Inpatient hospital | |
| Outpatient hospital | |
| Physician/ advanced registered nurse practitioner | |
| Dental | Limited as determined by the medical home provider. |
| Smoking cessation medication and counseling | |
| Pharmacy | Only if prescribed as part of an inpatient hospital stay. IowaCare members receive a 10-day supply of prescription medication to take home after an inpatient hospital discharge |
| Durable Medical Equipment | Only if provided as part of an inpatient hospital stay |
| Obstetric services | Only available to Demonstration Population 2 (Spend-down pregnant women) |
| Annual comprehensive medical examination and appropriate lab tests | May be received from any Medicaid-certified physician, advanced registered nurse practitioner, or physician assistant as described in section VII, paragraph 2. Once a member is assigned to a medical home, the member must receive this benefit through the medical home. |

## VI. COST SHARING

22. **Co-Payments.** Enrollees will be subject to the same co-payments as required under the Medicaid State plan.

23. **Premiums.** Premiums may be charged to individuals as follows:

| Annual Household Income | Maximum Monthly Premium |
|---|---|
| All enrollees above 150% through 200% of the FPL | No more than one-twelfth of 5 percent of the individual's annual family income |

24. **Hardship Waiver.** An IowaCare member who submits a written statement or signs the hardship statement on the IowaCare billing statement indicating that payment of the monthly premium will be a financial hardship will be exempted from premium payment for that month. If the statement is not postmarked by the premium due date, the member shall be obligated to pay the premium and will owe an outstanding debt to the State.

25. **Total Aggregate Out of Pocket Expenditures.** The total aggregate amount of IowaCare premiums and cost sharing, Medicaid cost sharing, and CHIP premiums and cost sharing must not exceed 5 percent of family income. Family income must be determined in the same manner as was used to determine eligibility. The State must develop a process for ensuring that families do not exceed the 5 percent cost sharing limit, and must include a description of this process in the first quarterly report required in section VIII, paragraph 36, and in each annual report required in section VIII, paragraph 37.

26. **Cost Sharing for Certain American Indian/Alaskan Native Eligibles.** No premium shall be imposed on American Indian/Alaskan Native individuals enrolled in the Demonstration who is furnished an item or service by an Indian Health Provider, or through referral to contract health services. No cost sharing shall be charged to such individuals for services furnished through Indian Health Providers or under contract health services. These limitations give effect to the exemptions described in section 5006 of the American Recovery and Reinvestment Act of 2009.

## VII. DELIVERY SYSTEMS

27. **Regional Primary Provider Network.** IowaCare members are assigned to a medical home based on region and county designation. IowaCare members also receive hospital services based on region. Tertiary and quaternary care is provided by the University of Iowa Hospitals and Clinics (UIHC) statewide.

    a. The State will submit to CMS for approval a schedule of the medical homes that will be available in each region/county. The State must provide CMS 30-day notice of any changes to medical home assignments. This notice will be deemed approved unless CMS, within that 30 day period, raises concerns about beneficiary access. The approved schedule will also be publicly available.

    b. **Spend-Down Pregnant Women** - Spend-down pregnant women may also receive obstetric services from any Medicaid-certified provider, unless the beneficiary resides in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington counties, in which case the beneficiary must receive obstetric services from the University of Iowa Hospitals and Clinics.

The provider network for Spend-Down Pregnant Women is also described in the Table 3 below:

Table 3

| Population Description | Provider | Covered Services |
|---|---|---|
| Women who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington counties. | University of Iowa Hospitals and Clinics | Obstetric services provided in an inpatient hospital, outpatient hospital, or physician office |
| Women who reside in counties other than Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington | Any Medicaid-certified physician or Advanced Registered Nurse Practitioner | |

28. **Annual Comprehensive Medical Examination**. Prior to being assigned to a medical home, IowaCare members may receive an annual comprehensive medical examination and appropriate lab tests, from any Medicaid-certified physician, advanced registered nurse practitioner, or physician assistant. IowaCare members must obtain any follow-up services from the primary IowaCare provider network described in the paragraph above (section VII, paragraph 27). IowaCare members who are assigned to a medical home may only receive the annual comprehensive medical examination through the medical home.

29. **Additional Primary Care-Related Provider Network**. Beginning October 1, 2010, and subject to the level of funding appropriated by the Iowa State Legislature as described below, the State may phase in the addition of FQHCs into the provider network to provide primary care services. Beginning October 1, 2010, the FQHCs located in Sioux City and Waterloo will be added to the provider network for primary care services.

    The State is not required to provide services via the additional primary care-related provider network, if expenditures for such services exceed the total computable amount for each DY as described in the Table 4 below.

    Table 4

| DY | Estimated Total Computable Amount Available for Services Provided by the Additional Primary-Care Related Provider Network |
|---|---|
| DY 6 | $6 million |
| DY 7 | $10 million |
| DY 8 | $10 million |
| DY 9 | $5 million |

30. **IowaCare Medical Home.** Within the Demonstration the Medical Home is defined as "an approach to providing comprehensive primary care, that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient's family." To accomplish this objective:
    a. By October 1, 2010, the State must establish a medical home model for all network providers as described in paragraph 27 and include medical home certification requirements, payment methods, and provider performance measurement, and update the

evaluation design. These elements must be approved by CMS accordingly.

b. The State may require IowaCare members who reside in counties within the service region of the medical home to utilize the "assigned" medical home prior to accessing specialty or hospital services through other network providers.
c. Certified medical homes may receive a per member per month payment between $2 and $5 for services rendered consistent with OMB circular A-87.
d. Medical home incentive payments shall comply with the requirements of Attachment B.

31. **Services Covered Outside the Primary Provider Network.**
    a. Beginning October 1, 2010, and subject to the level of funding appropriated by the Iowa State Legislature, IowaCare members may receive emergency services from hospitals other than the University of Iowa Hospitals and Clinics and Broadlawns Medical Center if i., ii., and iii. are met as described below.
        i. Either:
            - The services are emergency services and it is not medically possible to postpone provision of services and transfer the individual to a primary network provider, or
            - The beneficiary cannot be transferred to a primary network provider due to a lack of inpatient capacity.

        ii. The individual is enrolled in Demonstration Population 1 at the time treatment is provided for the services to be covered.

        iii. The hospital is located in Iowa.

        Covered services must include emergency services, as designated by the State, and medically necessary treatment up to the point the beneficiary is medically stable and may be transferred to a primary network provider. Covered services are limited to services covered for primary network providers.

        The State is not required to provide emergency services covered outside the primary care provider network services, if expenditures for such services exceed the total computable amount for each DY as described in Table 5 below.

Table 5

| **DY** | **Estimated Total Computable Amount Available for Emergency Services Covered Outside the Primary Provider Network** |
|---|---|
| DY 6 | $2 million |
| DY 7 | $3 million |
| DY 8 | $3 million |
| DY 9 | $1.5 million |

32. **IowaCare Safety Net Care Pool (I-SNCP)** was established November 1, 2011, to ensure support for the provision of health care to IowaCare members by hospitals, clinics, and other providers allowable under STC 32. The State is authorized to claim Federal Financial Participation (FFP), subject to limits under STC 32 and applicable Federal requirements, for expenditures made for uncompensated care provided to IowaCare individuals with no other source of third party coverage for the services identified below furnished by Broadlawns

Medical Center, University of Iowa Hospitals and Clinics, or other providers allowable under STC 32. The services identified, below, must meet the definition of such covered services in section 1905(a) of the Act and the approved Iowa State plan. The State must identify the provider and the source of the non-federal share for all expenditures under STC 32.

a. **Use of I-SNCP Funds** - The State is authorized to claim expenditures identified in STC 32(b) that are incurred by hospitals, clinics, or by other provider types allowable under STC 32 for uncompensated medical care costs of medical services provided to IowaCare members, as agreed upon by CMS and the State. Expenditures are claimed in accordance with CMS-approved claiming protocols.

b. **Allowable I-SNCP Expenditures** - Iowa may claim FFP for expenditures, based on payment methodologies approved in Attachment A, in the following defined categories of spending:

1. **Broadlawns Medical Center –** The purpose of this funding is for durable medical equipment and pharmacy services provided to IowaCare members assigned to Broadlawns as a medical home and is limited to outpatient prescription drugs, beyond the current 10-day supply of prescription medication after an inpatient hospital discharge that is included in the benefit package for all IowaCare members.
2. **Care Coordination** - The purpose of this funding is to defray costs being borne by the IowaCare participating providers for services necessary to ensure a positive outcome for the member after an inpatient hospitalization. IowaCare providers and non-IowaCare providers may be reimbursed for limited medically necessary services or equipment provided to enrolled IowaCare members subject to the limitations below. Providers must be participating Medicaid providers. All Medicaid rules regarding the provision of the service will apply (e.g. prior authorization, etc.). Payable services are limited to:
    a. Durable Medical Equipment (DME) – above the available DME benefit that is included in the IowaCare benefit package for all members;
    b. In-home health care; and
    c. Rehabilitation & therapy services.

3. **Lab & Radiology Services** - The purpose of this funding is to defray costs being borne by Federally Qualified Health Centers, participating in IowaCare as a medical home, who do not have the necessary laboratory testing and radiology equipment on site. Each participating FQHC will identify up to 4 laboratories and 4 radiology sites to which IowaCare members will be referred. Each provider will be assigned unique IowaCare provider numbers under which claims for IowaCare members will be submitted. Claims will also include the IowaCare provider number of the referring FQHC. Only Medicaid-covered services provided by the designated enrolled participating Medicaid providers are payable. All Medicaid rules regarding the provision of the service will apply (e.g. prior authorization, etc.). Beginning January 10, 2013, providers of laboratory

and radiology services will work with the state and FQHCs to ensure access for to these services. Agreement will be reflected in Attachment A.

c. **I-SNCP Annual Limits** – The total computable annual limits for I-SNCP cannot exceed the following:

1. DY 7 - $6,000,000
2. DY 8 - $5,500,000
3. DY 9 - $2,750,000

d. **Provider-Specific Cost Limit for Certain I-SNCP Expenditures.** The payments authorized under STC 32 are also limited on a provider-specific basis to the cost of providing approved Medicaid State plan services as identified in a reimbursement and cost protocol, to be approved by CMS and included in Attachment A, to IowaCare members, less payment received by or on behalf of such individuals for such services.

i. Broadlawns Pharmacy Payments
ii. Care Coordination Payments
iii. Lab & Radiology Payments: January 1, 2013, lab & radiology payments through this pool will sunset.

For payments under STC 32(b), the State must require each eligible provider to report cost and payment data on services eligible for reimbursement under this component of the I-SNCP in a manner that adheres to Medicare cost principles as they are represented on the Medicare cost report. For those eligible providers that do not currently complete a Medicare cost report or any other cost report, the State and CMS shall develop an agreed upon methodology to determine a proxy for uncompensated cost.

The State must submit for CMS approval a reimbursement and cost protocol that will establish rules and guidelines for the State to claim FFP for the provider payments, including a demonstration that payments do not exceed eligible uncompensated costs. This protocol will be incorporated into Attachment A. The State must submit a draft revised Attachment A by January 1, 2012. The protocol must be finalized by March 1, 2012. Federal financial participation is not available for payments under STC 32 after July 1, 2012 if the reimbursement and cost protocol is not approved. Federal matching will resume once the protocol is approved. The protocol must include precise definitions of eligible uncompensated provider costs and revenues that must be included in the calculation of uncompensated cost. The protocol must also identify the allowable source documents to support costs; it must include detailed instructions regarding the calculation and documentation of eligible costs and the tool used by the State and hospitals to apply for provider payments. The protocol must also include payment timeframes and amounts available to particular providers within the annual pool limits. For those eligible providers that do not currently complete a Medicare cost report or any other cost report, the protocol must include precise definitions of how the proxy for uncompensated costs and revenues shall be calculated. The protocol must also identify the allowable source documents to

support the proxy uncompensated costs; it must include detailed instructions regarding the calculation and documentation of eligible proxy uncompensated costs and any tool used by the State.

## VIII. GENERAL REPORTING REQUIREMENTS

33. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in these STCs.

34. **Reporting Requirements Related to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in this agreement. The State must submit any corrected budget neutrality data upon request.

35. **Monthly Calls**. CMS will schedule monthly conference calls with the State. 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, the benefit package, cost-sharing, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS will update the State 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.

36. **Quarterly Progress Reports.** The State must submit progress reports within 60 days following the end of each quarter (March, June, September, and December of each year). The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

    a. An updated budget neutrality monitoring spreadsheet;
    b. A discussion of events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues.
    c. Action plans for addressing any policy, administrative, or budget issues identified.
    d. Quarterly enrollment reports for Demonstration eligibles, that include the member months and end of quarter, point-in-time enrollment for each Demonstration population;
    e. Evaluation activities and interim findings;
    f. Progress meeting the benchmarks outlined in section XI; and,
    g. Other items as requested.

37. **Annual Report.** The State must submit a draft annual report documenting accomplishments such as success in meeting the benchmarks listed in section XI, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties and solutions in the operation of the Demonstration.

The State must submit the draft annual report no later than 120 days after the close of the Demonstration Year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

38. **Annual Program Compliance Evaluation.** Within 1 year of the closing date of each SFY, the State must submit an annual evaluation documenting Iowa medical assistance program compliance with the following:
    a. That providers retain 100 percent of the total computable payment of expenditures claimed under title XIX of the Act.

## IX. GENERAL FINANCIAL REQUIREMENTS

39. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide Federal Financial Participation (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 X (Monitoring Budget Neutrality).

40. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** 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 Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. 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 (11-W-00189/7) assigned by CMS, including the project number extension, which indicates the DY in which services were rendered.

    b. **Reporting of IowaCare Premiums.** The State must report IowaCare premiums that are collected by the State each quarter on Form CMS-64 Summary Sheet line 9.D., columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64 narrative, with subtotals by DY.

    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 Lines 7 and 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

    d. **Use of Waiver Forms.** The following three (3) waiver forms CMS-64.9 Waiver and/or

64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the Demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

i. "Expansion Pop." (Expansion Population) expenditures,
ii. "Spnd-dwn Preg. Wmn." (Spend-down Pregnant Women) expenditures.
iii. "I-SNCP" (Iowa Safety Net Care Pool) expenditures

e. **Pharmacy Rebates.** The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the Demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the Demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

f. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" refers to all title XIX expenditures on behalf of the individuals who are enrolled in this Demonstration, as defined in STC 14, including all service expenditures net of premium collections and other offsetting collections. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

g. **Title XIX Administrative Costs.** Administrative costs will not be subject to the budget neutrality expenditure limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

h. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any claims documented through 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 documented through 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 CMS-64 waiver forms the net expenditures related to dates of service during the operation of the section 1115 Demonstration, in order to properly account for these expenditures in determining budget neutrality.

41. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of 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 the Form CMS-37 (narrative section) 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 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. CMS shall reconcile expenditures reported on the 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.

42. **Extent of Federal Financial Participation for the Demonstration** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the budget neutrality limits described in section XIX:

    a. Administrative costs, including those associated with the administration of the Demonstration;

    b. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration.

43. **Sources of Non-Federal Share.** The State provides assurance that the matching non-Federal share of funds for the Demonstration is derived from State/local monies. The State further assures that non-federal funds used to pay for Medicaid expenditures shall not be used as the matching funding for any other Federal grant or contract, except as expressly 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 at any time the sources of the non-Federal share of funding for the Demonstration. 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 provider 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.

44. **Monitoring the Demonstration.** The State must provide CMS with information to

effectively monitor the Demonstration, upon request, in a reasonable timeframe.

45. **Provider Taxes.** All provider taxes must comport with section 1903(w) of the Act and all other applicable Federal statutory and regulatory requirements.

46. **Payment Rates for IowaCare Services.** The methods and standards for establishing payment rates for IowaCare services are described in Attachment A.

## X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

47. **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 budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in section IX, paragraph 2.

48. **Risk.** The State shall be at risk for the both the number of enrollees in the Demonstration as well as the per capita cost for Demonstration eligibles under this budget neutrality agreement.

49. **Budget Neutrality Aggregate Cap.** Budget neutrality is determined on an aggregate cap basis as shown below in Table 6:

Table 6

| DY/ SFY | Annual Budget Neutrality Cap (Total Computable) |
|---|---|
| DY 1/ SFY 2006 | $102,200,000 |
| DY 2/ SFY 2007 | $109,354,000 |
| DY 3/ SFY 2008 | $117,008,780 |
| DY 4/ SFY 2009 | $125,199,395 |
| DY 5/ SFY 2010 | $133,963,352 |
| **Total DY 1 to DY 5** | **$587,725,527** |
| DY 6/ SFY 2011 | $143,340,787 |
| DY 7/ SFY 2012 | $153,374,642 |
| DY 8/ SFY 2013 | $164,110,867 |
| DY 9/ 07/01/2013 – 12/31/2013 | $87,799,314 |
| **Total for Extension Period** | **$548,625,610** |
| **Cumulative Total (Initial 5 Years Plus Extension Period)** | **$1,136,351,137** |

50. **Upper Payment Limit (UPL).** Payments under the Medicaid State plan (including any supplemental payments), when added to payments under the Demonstration, must not exceed the State's UPLs established at 42 CFR 447.272 and 42 CFR 447.321 for the following

services and classes of providers:

a. Inpatient hospital services – State government-owned or operated
b. Outpatient hospital services – State government-owned or operated
c. Nursing facility services – Non-State government-owned or operated
d. Nursing facility services – Privately-owned and operated

The State must continue to use a cost-based UPL methodology for State government-owned or operated outpatient hospital services. The State will annually review the outpatient UPL and, to the extent necessary, reduce claimed expenditures under the Demonstration to the extent the UPL is exceeded.

The Demonstration expenditures should be accounted for in all State plan UPL demonstrations, based on provider class and service type as identified in Table 7 below, to ensure that the sum of State plan and Demonstration expenditures do not exceed the applicable UPLs.

Table 7

| **Minimum Amounts by which State Plan Payments Must be Lower than UPL** | **DY 6** | **DY 7** | **DY 8** | **DY 9** | **3.5 Year Total** |
|---|---|---|---|---|---|
| State Government Inpatient Hospital | $6,191,661 | $8,234,499 | $10,320,236 | $6,224,887 | $30,971,283 |
| State Government Outpatient Hospital | $6,258,670 | $6,671,086 | $7,088,452 | $3,755,413 | $23,773,621 |
| Non-State Government Nursing Facility | $6,328,779 | $5,743,268 | $6,404,191 | $3,539,496 | $22,015,734 |
| Private Nursing Facility | $124,561,677 | $132,725,789 | $140,297,988 | $74,279,518 | $471,864,972 |
| Total | $143,340,787 | $153,374,642 | $164,110,867 | $87,799,314 | $548,625,610 |

51. **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 IowaCare.

52. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis, by combining the annual limits calculated following section X, paragraph 49 into lifetime limits for the Demonstration. If at the end of this Demonstration period the budget neutrality limit has been exceeded, the State assures CMS that the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall

be based on the time elapsed through the termination date. The following describes how budget neutrality is enforced.

a. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an assessment of the State's compliance with these requirements shall be based on the time elapsed through the termination date.

b. **Interim Checks/ Corrective Action Plan.** If the State exceeds the calculated cumulative target limit by the percentage identified below in table 8 for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

Table 8

| **DY** | **Cumulative Target** (Total Computable Funds) | **Cumulative Target Definition** | **Percentage** |
|---|---|---|---|
| DY 6 | $144,774,195 | Year 6 budget neutrality cap plus: | 1 percent |
| DY 7 | $298,199,006 | Years 6 and 7 combined budget neutrality caps plus: | 0.5 percent |
| DY 8 | $460,826,296 | Years 6 through 8 combined budget neutrality caps plus: | 0 percent |
| DY 9 | $548,625,610 | Years 6 through 9 combined budget neutrality caps plus: | 0 percent |

## XI. BENCHMARKS

53. The State shall work to meet the following benchmarks during the extension period:

a. Increase local access to primary and preventative care for Demonstration Population 1 by expanding the provider network to include FQHCs. By October 1, 2010, add at least one FQHC in the most underserved region of the State. By December 1, 2010, submit a plan to CMS to phase-in additional FQHCs.

b. Decrease hospital uncompensated care and medical debt burdens for Demonstration Population 1 by adding limited payment to non-network hospitals for emergency treatment when the member is not able to access a network provider. By October 1, 2010, establish the requirements and protocols for payment to non-network hospitals. –

c. By October 1, 2010, establish a medical home model within the primary provider network, including medical home certification requirements, payment methods, provider performance measurement, and evaluation within the Demonstration evaluation design. The specific goals of the medical home model are the following:
   i. Establish three medical home sites in DY 6 and by December 1, 2010, develop a plan for expanding the number of medical home sites through the Demonstration period.
   ii. By October 1, 2010, establish minimum requirements for a medical home.
   iii. Collaborate by participating in quarterly meetings with the Iowa Medical Home Advisory Committee in developing the medical home model.
   iv. Improve health care outcomes for members with chronic disease through medical home care coordination and use of disease registries.
   v. Decrease utilization of high cost and geographically difficult to access specialty and

hospital care through medical home care management.

vi. Add payment for peer consultation for medical home/ specialty consultation to reduce the need for travel to the UIHC for specialty care.
vii. Increase beneficiary self-management skills and primary care engagement.
viii. Implement at least one disease management program within each medical home.
ix. By October 1, 2010, establish a payment methodology for a medical home.
x. By October 1, 2010, establish performance measurements for medical homes.
xi. By July 1, 2011, develop a plan for expanding the medical home model in the full-benefit Medicaid program.
xii. Include information on the above elements in the required quarterly and annual reports to CMS.– See Attachment B

d. Increase the adoption and meaningful use of Electronic Health Records (EHR) and Health Information Exchange (HIE) by primary network providers in the Demonstration. All primary network providers will either have an EHR, or will have a plan and timeframe for adopting an EHR.
   i. As a minimum requirement for all medical homes, the medical home site must have a disease registry in operation that it uses to manage at least 1 chronic disease.
   ii. The State must collaborate with the State's HIE designated entity to ensure that primary network providers are a high priority for connecting to the State's HIE.
   iii. The State may facilitate the exchange of electronic information, as a transition to the Statewide HIE, among network providers if feasible.
   iv. By July 1, 2011, network providers will achieve adopt, implement, upgrade, or meaningfully use certified EHR technology. Network providers will connect to and utilize the statewide HIE.

e. By January 1, 2011, develop a quality assurance plan for the Demonstration. The State will collaborate with CMS to select adult quality measures, means and frequency of data/measure collection, and how the quality measures will be used for program improvement.

f. The State must continue to provide coverage of smoking cessation drugs and counseling programs and must monitor usage and success of the programs in reducing smoking among recipients of medical assistance and expansion population members.

g. The State must review the potential costs of paying for transportation to and from a provider included in the expansion population provider network under this Demonstration. The State will report the results of the review by December 15, 2010. – ACCOMPLISHED

h. The State is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the ACA for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the ACA. The State must submit a draft to CMS by July 1, 2012, with progress updates included in each quarterly report. The State will revise the Transition Plan as needed.

## XII. EVALUATION

54. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval within 120 days from the award of the Demonstration extension a draft evaluation design which includes how the State will evaluate the medical home component of the Demonstration. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the Demonstration. The draft design must discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. .

55. **Interim Evaluation Reports**. In the event the State requests to extend the Demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

56. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

57. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

## XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

| Date – Specific | Deliverable | STC Reference |
|---|---|---|
| 12/01/2010 | Submit plan to phase-in additional FQHCs | Section XI, paragraph 1 |
| 12/15/2010 | Submit results of review to cover transportation costs | Section XI, paragraph 1 |
| 01/01/2011 | Submit Draft Evaluation Design | Section XII, paragraph 1 |
| | | |
| **Annual** | By Nov. 1st - Draft Annual Report | Section VIII, paragraph 5 |
| | | |

| | | |
|---|---|---|
| **Quarterly** | Quarterly Progress Reports | Section VIII, paragraph 4 |

Payments to all providers in the provider network serving Demonstration Populations 1 and 2 shall be based on claims submitted by the providers for services furnished to the IowaCare Demonstration populations and adjudicated and paid by the Iowa Medicaid Enterprise. The payment will be made following guidelines of the regular Medicaid process. The claims submitted will be priced and paid according to the reimbursement methodologies described below.

## A. Inpatient Hospital Services Provided by Primary Provider Network

Broadlawns Medical Center

Broadlawns Medical Center claims submitted will be priced according to the approved Medicaid reimbursement methodology as of November 1, 2011, which is based on a diagnosis resource group (DRG) methodology. The only difference between the methodology to price IowaCare claims versus Medicaid state plan claims is the level of the DRG base rate. On November 1, 2011, DRG base rates were updated to reflect the triennial rebase of inpatient DRG base rates and DRG weight recalibration processes. Two separate DRG base rates were calculated for Broadlawns Medical Center: a) DRG base rate that includes the hospital health care assessment inflation factor and b) DRG base rate that does not include the hospital health care assessment inflation factor. The DRG base rate that includes the hospital health care assessment inflation factor will be used for Medicaid state plan services; however the DRG base rate that excludes the hospital health care assessment inflation factor will be used for IowaCare services. Payment will be made to Broadlawns Medical Center based on this pricing, and that payment will be the basis for drawing down Federal funding.

University Iowa Hospital and clinics (UIHC)

Inpatient hospital services provided by UIHC will be paid based on 100 percent of reasonable and allowable cost. An interim rate based on the approved Medicaid reimbursement methodology as of November 1, 2011 which is based on a diagnosis resource group (DRG) methodology shall be used to price submitted claims on an interim basis. The only difference between the interim methodology to price IowaCare claims versus Medicaid state plan claims is the level of the DRG base rate. On November 1, 2011, DRG base rates were updated to reflect the triennial rebase of inpatient DRG base rates and DRG weight recalibration processes. Only one DRG base rate was calculated for UIHC. This DRG base rate, which does not include the hospital health care assessment inflation factor will be used for both Medicaid state plan services and IowaCare services. Effective November 1, 2011, inpatient claims submitted will be priced and used to draw down federal funding on an interim basis according to the interim rate methodology noted above. These amounts will be subject to reconciliation with certifications of actual reasonable and allowable costs incurred by UIHC, based on cost reports, and claimed federal funding will be adjusted based on that reconciliation. The UIHC shall utilize certified public expenditures as the State share of at least $20 million but not to exceed $32 million of total expenditures (Federal plus non-federal share) Claims shall be paid at 100% however each month the non-federal share shall be recouped by the Department using a gross adjustment process in the MMIS.

Once the cost of services exceeds the certified public expenditure amount provided by UIHC, the remaining cost of services will be reimbursed at the total computable amount with the nonfederal share being provided by the state through a legislative appropriation,

Interim Reconciliation
The hospital certification shall be verified by a Department of Human Services interim reconciliation of the hospitals' as-filed CMS 2552 cost report, for the payment period, and IowaCare claims data as extracted from MMIS by the Department for the year for which interim reconciliation is being performed.

The following process is used to determine inpatient hospital costs, including capital and medical education using the hospital costs, charges and patient days from the as-filed CMS 2552 cost report. In addition IowaCare supplemental cost report schedules detailing IowaCare patient days and IowaCare charges by line item are required to be submitted by hospitals with the CMS 2552-96.

**Step 1**
Total hospital cost, for each routine and ancillary cost center, is identified from Worksheet B, Part I, Column 25, lines 25 through 95.
Observation bed costs, to be reported on ancillary cost center line 62, are identified by taking Worksheet B Part I Column 25, Line 25, excluding swing bed nursing facility costs from Worksheet D-1, line 26, and dividing by total inpatient days from Worksheet D-1, Column 1, Line 2. This is then multiplied by observation days from Worksheet D-1, Line 83. Observation costs are also calculated for any sub-providers if applicable. Total hospital patient days for each inpatient routine cost center is identified from Worksheet S-3 Part I Column 6.

Note that Worksheet B, Part I, Column 25 should be the same as Worksheet B, Part I, Column 27 plus Columns 22 and 23. If not, then Column 27 plus Columns 22 and 23 should be used instead.

**Step 2**
For each routine cost center, the cost and total hospital patient days from step 1 represent the total hospital cost and days for purposes of determining the a calculated per diem cost for the routine cost center.

For each ancillary cost center, the cost from step 1 above and the total charge from step 3 below represent the total hospital cost and charge for purposes of determining the cost-to-charge ratio for the ancillary cost center.

**Step 3**
The hospital's total charges by cost center are identified from Worksheet C Part I Column 8.

**Step 4**

The State will calculate a per diem cost for each routine cost center. For each inpatient routine cost center, a per diem cost is calculated by dividing total hospital cost, for each respective cost center, from Step 1, Worksheet B, Part I, Column 25, line 25 through 33, divided by total days identified, for each respective cost center, in Step 1 from Worksheet S-3, Part I Column 6. Long term care cost centers are excluded from this process. The A&P routine per diem, in accordance with CMS 2552 Worksheet D-1, is computed by including observation beds days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The State will calculate a cost to charge ratio for each ancillary cost center. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total hospital cost from Step 1, for the respective ancillary cost center, by the total hospital charge from Step 3, for the respective ancillary cost center.

**Step 5**
To determine the inpatient hospital routine and ancillary cost center costs for the payment period, the hospital's IowaCare inpatient hospital days and IowaCare inpatient hospital charges from MMIS paid claims data are used. The IowaCare paid days and charges are identified for the hospital inpatient services that correspond to the payment period covered by the cost report. The IowaCare days and charges should not include days and charges pertaining to any non-hospital inpatient services or any outpatient services (such as long-term care services and physician professional services). The actual IowaCare days for each respective routine cost center are multiplied by the per diem amount from Step 4 for each respective routine cost center to arrive at the payment period's IowaCare routine cost. The actual IowaCare charges for each respective ancillary cost center are multiplied by the cost to charge ratios from Step 4 for each respective ancillary cost center to arrive at the payment period's IowaCare ancillary cost. To arrive at IowaCare's share of the hospital's allowable organ acquisition costs for each organ type, the ratio of IowaCare organs to total usable organs (worksheet D-6, line 54) is applied to the total allowable organ acquisition costs (worksheet D-6, line 53, Part A column). IowaCare organs are defined as those organs transplanted into an IowaCare patient.

**Step 6**
The total IowaCare inpatient hospital costs calculated in Step 5 are offset by all payments (other than the interim payments made under this protocol) received by the hospital for IowaCare inpatient hospital services. The resulting net IowaCare inpatient hospital cost is compared to the total computable interim payments made under this protocol including the total computable expenditure certified by UIHC. Payments made in excess of the total net IowaCare inpatient hospital costs shall be recouped by the State. No additional payments will be made to UIHC if the interim payments are less than the total net IowaCare inpatient hospital costs.

**Final Reconciliation**
The Department of Human Services' final reconciliation with a qualifying hospital is calculated using the same methodology as is used when calculating the interim reconciliation except that the data source used will be based on the hospital's finalized CMS 2552 cost report from the

Medicare fiscal intermediary for the payment period and the most updated IowaCare claims and payment data, extracted for the July 1 through June 30 payment period for which final settlement is being performed.

## B. Outpatient Hospital Services Provided by Primary Provider Network

Provider claims submitted will be priced and paid to providers according to the approved Medicaid reimbursement methodology as of November 30, 2009 with the following exceptions. The differences between the methodology to price IowaCare claims versus Medicaid state plan claims are the level of the APC base rate and the fee schedule amounts. As of December 1, 2009, the Medicaid state plan APC base rates for both Broadlawns and UIHC were reduced by five percent to implement the Governor's Executive Order 19. This rate reduction was not applied to the APC base rate for IowaCare services. In addition, effective July 1, 2010, a rate increase will be applied to Broadlawns' and UIHC's APC base rates for Medicaid state plan services, however this rate increase will not be provided to Broadlawns' APC base rate for IowaCare services.

Effective January 1, 2012, APC base rates will be updated to reflect the triennial outpatient hospital rebase process. Two separate APC base rates will be calculated for Broadlawns Medical Center: a) APC base rate that includes the hospital health care assessment inflation factor and b) APC base rate that does not include the hospital health care assessment inflation factor. The APC base rate that includes the hospital health care assessment inflation factor will be used for Medicaid state plan services; however the APC base rate that excludes the hospital health care assessment inflation factor will be used for IowaCare services. Only one APC base rate will be calculated for UIHC. This APC base rate, which does not include the hospital health care assessment inflation factor will be used for both Medicaid state plan services and IowaCare services.

Any fee schedule amounts shall be the agency's rates set as of July 1, 2008, except for preventative exam codes in which the fee schedule amounts shall be the agency's rates set as of July 1, 2010. Payments to UIHC, as indicated in the STCs must be reconciled with the applicable cost-based UPL annually.

## C. Non-hospital Services Provided by Primary Provider Network

Provider claims submitted will be priced and paid to providers according to the Medicaid fee schedule amounts. The fee schedule amounts shall be the agency's rates set as of July 1, 2008, except for preventative exam codes in which the fee schedule amounts shall be the agency's rates set as of July 1, 2010. Fee schedule amounts will be updated annually based upon legislative approval of fee schedule rate increases or decreases. Annual changes are not guaranteed but are made only if approved by the Iowa General Assembly.

## D. Provider Network Expansion Services, i.e. FQHC Services Provided by Primary

**Provider Network**

Effective January 1, 2013, the Federally Qualified Health Center (FQHC) reimbursement methodology for IowaCare will be changed from fee schedule payment to an encounter payment and the Radiology and Laboratory pool will sunset December 31, 2012.

The encounter rate paid to the FQHC is intended to cover costs borne by the FQHC for laboratory and radiology services provided to IowaCare members by non-in-house providers. The cost of laboratory and radiology services provided by non-in-house providers is reportable as a contracted cost to the FQHC on their cost report for tracking purposes.

The FQHC encounter rate would be established at an amount that would result in budget neutral expenditures to the current IowaCare budget. DHS would review the claims information for each FQHC submitted for IowaCare as well as the claims submitted by referral labs to determine a budget neutral encounter rate for each FQHC. DHS would also utilize claims data to determine the number of encounters each FQHC had provided to IowaCare members.

The IowaCare encounter payments made to the FQHC would not be subject to retroactive cost settlement.

An encounter can only be billed when the IowaCare member has a face-to-face meeting with a professional staff member of the FQHC, such as a physician or nurse and/or physician assistant under the supervision of a physician.

The reimbursement methodology established is budget-neutral to current IowaCare expenditures for the FQHC and the radiology and laboratory pool.

## E. Services Provided Outside the Primary Provider Network, i.e. Non-participating Hospitals

For hospital services, claims submitted will be priced according to the approved Medicaid reimbursement methodology as of June 30, 2010 and shall be updated to reflect the triennial inpatient and outpatient rebases. For non-hospital services, claims submitted will be priced according to the Medicaid fee schedule amounts. The fee schedule amounts shall be the agency's rates set as of July 1, 2010. Fee schedule amounts will be updated annually based upon legislative approval of fee schedule rate increases or decreases. Annual changes are not guaranteed but are made only if approved by the Iowa General Assembly.

## F. IowaCare Safety Net Care Pool (I-SNCP)

### 1. Broadlawns Medical Center

a. Methodology for those services in which costs would not be reported on neither the

Medicare or Medicaid cost report (includes services such as optometry, podiatry and durable medical equipment)

Each covered procedure shall be billed and priced according to the methodology under the most current approved Medicaid State plan in effect as of the date of service submitted on the claim. At the end of each state fiscal year, a provider-specific basis comparison between payments received for services provided to IowaCare members and the actual cost of providing the service to IowaCare members (less any payment received by or on behalf of such individual for such services) shall be completed. Because these service providers do not currently complete a Medicare or Medicaid cost report the actual cost cannot be determined. Therefore, the following process will be used to determine a proxy for the cost of providing the service instead of actual cost.

The cost of providing the service shall be calculated at the claim level. For all paid claims, the allowable charge submitted on the claim shall be multiplied by an appropriate cost to charge ratio to determine a proxy for the cost of providing the service. The proxy costs calculated for each claim shall be summed to determine the total proxy cost of providing the service. The total proxy cost is then compared to the total payments made to the provider for the same set of claims and service. The total payment is the sum of IowaCare payment plus any payment received by or on behalf of such individual for such services received.

The cost to charge ratio shall be determined based on review of financial data submitted by the service provider. If possible a separate cost to charge ratio will be established for each type of service. If financial data is not detailed enough an overall cost to charge ratio will be determined and applied to all claims.

b. Pharmacy Services

Pharmacy claims will be priced according to the methodology under the most current approved Medicaid State plan. Broadlawns Medical Center Retail Pharmacy participates in the 340B drug pricing program. Iowa Medicaid policy states that any provider purchasing drugs through the 340B program is required to bill Medicaid the actual acquisition cost (AAC) plus the dispensing fee. Therefore, due to this billing requirement, Medicaid payment will not exceed the actual cost of the drug. A postpayment review will be conducted to ensure that AAC was submitted on the claim. In addition to the postpayment review, Broadlawns Medical Center will be required to complete an annual dispensing fee survey. This survey will be used to determine the actual cost of dispensing which will then be compared to total dispensing fee payments received. Iowa Medicaid is in the process of developing a dispensing fee survey that will be used to survey all pharmacies doing business with Iowa Medicaid in the Summer of 2012. This same dispensing fee survey will used to calculate the actual cost of dispensing for Broadlawns.

## 2. Care Coordination

a. Methodology for those services in which costs would not be reported on neither the Medicare or Medicaid cost report (includes services such as durable medical equipment and rehabilitation and therapy)

Each covered procedure shall be billed and priced according to the methodology under the most current approved Medicaid State plan in effect as of the date of service submitted on the claim. At the end of each state fiscal year, a provider-specific basis comparison between payments received for services provided to IowaCare members and the actual cost of providing the service to IowaCare members (less any payment received by or on behalf of such individual for such services) shall be completed. Because these service providers do not currently complete a Medicare or Medicaid cost report the actual cost cannot be determined. Therefore, the following process will be used to determine a proxy for the cost of providing the service instead of actual cost.

The cost of providing the service shall be calculated at the claim level. For all paid claims, the allowable charge submitted on the claim shall be multiplied by an appropriate cost to charge ratio to determine a proxy for the cost of providing the service. The proxy costs calculated for each claim shall be summed to determine the total proxy cost of providing the service. The total proxy cost is then compared to the total payments made to the provider for the same set of claims and service. The total payment is the sum of the Care Coordination payments plus any payment received by or on behalf of such individual for such services received.

The cost to charge ratio shall be determined based on review of financial data submitted by the service provider. If possible a separate cost to charge ratio will be established for each type of service. If financial data is not detailed enough an overall cost to charge ratio will be determined and applied to all claims.

b. Methodology for those services in which costs are reported on either the Medicare or Medicaid cost report (includes services such as rehabilitation and therapy and skilled nursing services)

Each covered procedure shall be billed and priced according to the methodology under the most current approved Medicaid State plan in effect as of the date of service submitted on the claim. At the end of each state fiscal year, a provider-specific basis comparison between payments received for services provided to IowaCare members and the actual cost of providing the service to IowaCare members (less any payment received by or on behalf of such individual for such services) shall be completed.

Based on the service provided, the appropriate Medicare and Medicaid cost report that is currently required to be submitted to Iowa Medicaid under the approved Medicaid State plan will be used to calculate the cost of providing the service using Medicare cost reporting and payment

principles. The total cost calculated is then compared to the total payments made to the provider for the same service. The total payment is the sum of the Care Coordination payments plus any payment received by or on behalf of such individual for such services received.

### 3. Lab & Radiology Services

Each covered procedure shall be billed and priced according to the methodology under the most current approved Medicaid State plan in effect as of the date of service submitted on the claim. At the end of each state fiscal year, a provider-specific basis comparison between payments received for services provided to IowaCare members and the actual cost of providing the service to IowaCare members (less any payment received by or on behalf of such individual for such services) shall be completed. Because lab and radiology providers do not currently complete a Medicare or Medicaid cost report the actual cost cannot be determined. Therefore, the following process will be used to determine a proxy for the cost of providing the service instead of actual cost.

The cost of providing the service shall be calculated at the claim level. For all paid claims, the allowable charge submitted on the claim shall be multiplied by an appropriate cost to charge ratio to determine a proxy for the cost of providing the service. The proxy costs calculated for each claim shall be summed to determine the total proxy cost of providing the service. The total proxy cost is then compared to the total payments made to the provider for the same set of claims and service. The total payment is the sum of the Lab and Radiology payments plus any payment received by or on behalf of such individual for such services received.

The cost to charge ratio shall be determined based on review of financial data submitted by the service provider. If possible a separate cost to charge ratio will be established for each type of service. If financial data is not detailed enough an overall cost to charge ratio will be determined and applied to all claims.

It is anticipated that lab and radiology services will be provided by independent reference laboratories. However, if lab and radiology services are provided by a hospital, the cost of providing these services shall be calculated using the Medicare cost report that is currently required to be submitted to Iowa Medicaid using the Medicare cost reporting and payment principles outlined in the approved upper payment limit calculations as follows:

Total allowable Medicaid costs is identified through the step down cost apportionment process on the Medicare cost report using patient days and charges. Medicaid supplemental cost report schedules detailing Medicaid patient days and Medicaid charges by line item are required to be submitted by hospitals with the CMS 2552-96. In addition, Medicaid charges are available from the Medicaid PS&R.

Medicaid outpatient ancillary service cost is determined by multiplying Medicaid charges, per cost report line item, by the ancillary cost to charge ratio for each revenue

category discipline.

As of December 31, 2012, the methodology incorporating the use of the Radiology and Laboratory pool will sunset.

**Attachment B**

**IowaCare Special Terms and Conditions**

**Methods and Standards for Establishing Payment Rates for IowaCare Services**

## I. Background

1. IowaCare is an 1115 demonstration waiver that expanded Medicaid to 200% of the Federal Poverty Level for adults (age 19-64) who do not otherwise qualify for Medicaid. The coverage includes single adults and childless couples. The IowaCare program has a limited benefit package (inpatient/outpatient hospital, physician, limited dental and transportation), and a limited provider network. The provider network has been limited to two providers; Broadlawns Medical Center in Polk County, and the University of Iowa Hospitals and Clinics in Iowa City, which provides services statewide.
2. SF2356 as amended and passed by the Senate, expands the provider network under the current IowaCare program to include a regional primary care provider network, beginning with a phased in approach of Federally Qualified Health Centers (FQHC). The bill mandates the FQHCs selected by the Department of Human Services to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home.

## II. Goals

1. Increase IowaCare member satisfaction with health care.
2. Improve statewide access of IowaCare members to quality health care.
3. Reduce duplication of services.
4. Enhance communication among providers, family, and community partners.
5. Improve the quality of health care to IowaCare members through the patient-centered medical home model.
6. Promote and support a plan for meaningful use of health information exchange (HIE) in accordance with the Federal Register requirement.

## III. Iowa Care Medical Home Minimum Standards

**Medical homes in the IowaCare Medical Home Pilot must:**

1. Sign contract for three year commitment in Medical Home Pilot.
2. The provider shall meet Medical Home standards. If the Iowa Department of Public Health adopts rules that provide statewide medical home standards or provide for a statewide medical home certification process, those rules shall apply to the Medical Home Provider and shall take precedence over the requirements in this paragraph. At a minimum, the Medical Home Provider will:
   a. Have National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Level 1 recognition/certification or equivalent within 18 months of start of this contract. Medical homes recognition/certification status shall be designated as such for purposes of payment.
      i. Practices must complete NCQA PCMH Level 1 recognition (or the equivalent, as determined by the Department), transitioning to permanent recognition, as determined by the Medical Home Reform Committee.
      ii. Complete Transformed Baseline Assessment or Primary Care Development Corporation Baseline PCMH Self-Assessment to demonstrate practice readiness within the 20-day period prior to member enrollment and provide results to the Department within the same timeframe.

b. Demonstrate practice readiness within the 20-day period prior to member enrollment and provide results to the Department within the same timeframe.

c. Submit quarterly reports outlining progress toward obtaining national recognition to the Department until such time that a recognition status has been obtained. (Quarterly report template is located at http://www.ime.state.ia.us/docs/IowaCare_QuarterlyMedicalHomeActivityReport.docx)

3. Provide Provider Directed Care Coordination Services aimed at managing all aspects of a members care, ensuring quality of care and safety.
4. Develop a Continuity of Care Document (CCD) for each member that details important aspects of member's medical needs. This document will be updated and maintained by the medical home and will be updated as a means of communication between the referring provider and the consulting provider.
5. Submit a CCD and Personal Treatment Plan (PTP) prior to each referral
6. Complete a comprehensive evaluation. It is recommended (not required) that each medical home conduct or collect from recent medical history, a comprehensive evaluation including physical examination, and as indicated thereafter, based on age, gender, and risk factors and following established clinical guidelines. Following this guideline establishes a foundation that may lead to successful outcome and process measure reporting that is directly tied to the annual performance bonus as described in the Payment Methodology section. Each evaluation should include a personal treatment plan (PTP). Comprehensive evaluations may occur in conjunction with other services and may or may not be completed all at one time but should be associated with codes for preventive medicine, general medical or health examination and/or health supervision.
7. Provide access to care and information;
   a. Maintain system and written standards/protocols for tracking patient referrals, patient access and patient communication. Develop and maintain a secure connection between the FQHC and the referring center.
   b. Maintain -24 hours/day accessibility with a health care provider on call
   c. Provide onsite triage during regular office hours. Same-day services will be provided or arranged, if determined appropriate.
   d. Complete and submit activity reports, based on member access and specialty referrals, to the Department on a quarterly basis (Quarterly report template is located at http://www.ime.state.ia.us/docs/IowaCare_QuarterlyMedicalHomeActivityReport.docx).
8. Demonstrate the above components in the medical home's administrative policies and procedures.
9. Establish formal care management at the medical home.
   a. Designate a Dedicated Care Coordinator at each provider site. The dedicated care coordinator will be responsible for the following including, but not limited to:
      i. Providing care coordination.
      ii. Acting as a key contact person for each provider site.

iii. Providing members with community resources, information and support to assist member with adhering to PTP, including, but not limited to:
   a. Assisting member with medication adherence
   b. Assisting with appointment and referral scheduling and reminders
   c. Assisting with member wellness education, health support, and/or lifestyle modification and behavior changes
   d. Further responsibilities to be determined

10. Establish a disease management program. Each provider site will have at least one formal Diabetes Disease Management Program during the first year. Subsequent disease management programs will be added based on population-specific disease burden, or as directed by the Department. The Disease Management Program goals will be:
    a. Improve health outcomes using evidence based guidelines and protocols
    b. Report outcomes on a quarterly basis using evidence-based guidelines. Diabetes clinical outcomes will be measured for timeliness, completion, and results of $A_1C$, LDL, microalbumin, and eye examinations for each member identified with diabetes.
11. Establish a Wellness/Disease Prevention Program with quarterly reporting on quantities and activities. This program will:
    a. Promote behavior modification aimed at supporting health management (i.e., documented obesity counseling, tobacco cessation)
    b. Promote health screening based on age, gender, and health risks (i.e, Pap smears, mammograms, colon screening)
    c. Provide coaching for patient self-management; assisting members to both understand and mitigate identified risks.
12. Implement and/or utilize Health Information Technology (HIT);
    a. Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system.
    b. Establish a plan for meaningful use of health information exchange (HIE) in accordance with the Federal Register requirement.
    c. Report chronic conditions "registry data" once the IME registry guidelines are established. An assumption can be made that the guidelines will adopt the PQRI/Meaningful Use data format.
13. Develop or plan to develop a reminder service to inform members of appropriate preventative services. Each Medical Home will report on their process quarterly.
14. Develop or plan to develop an effective system of sharing clinical information with UIHC, and an efficient process for referrals to the UIHC for specialty care. Each center is to report on their process quarterly.

## IV. Payment System Methodology

1. Medical Services Payment.
   a. The Department will pay the Medical Home for medical services covered under the IowaCare program provided to enrollees assigned to the Medical Home according to the physician based fee-for-service reimbursement system in place in the Iowa Medicaid program. To the extent the Medical Home is an FQHC, it

must execute a separate enrollment with the IME, so as to facilitate non-FQHC encounter-based payment for Medical Home services.

2. Medical Home Payment
   a. A standard per member per month (PMPM) payment for enrollees assigned to the particular medical home shall be paid for complying with Medical Home minimum standards, as defined in section 1.4, during the first 18 months of operation and based on PCMH recognition/certification level of recognition in subsequent state fiscal years (SFY).
      i. The payment shall begin the first day of the month following the member's assignment to the medical home.
      ii. The payment will be made to the Medical Home the second Monday of each month.
      iii. The standard PMPM payment to the Medical Home can change based on the Medical Home's PCMH recognition/certification level at any time during the SFY, following the initial 18 month period.
      iv. The Medical Home shall receive a monthly Medical Home Payment for members in both Local and Remote Medical Home counties.
3. Performance Payment.
   a. A performance-based PMPM payment will be paid at the end of the SFY to the Medical Home contingent on meeting Medical Home performance measures, as defined in section 1.6, and available state funding.
      i. The Medical Home shall submit their annual performance report by August 1st or the first business day thereafter.
      ii. The performance payment shall be paid by October 31 or the first business day thereafter and is in addition to any other IowaCare reimbursement. This payment is calculated from the overall denominator reported on each Medical Homes' Annual Performance Report.
      iii. The Medical Home shall be measured against and paid the Performance Based Reimbursement for members that reside in both Local and Remote Medical Home counties.

| *Level of Recognition/Year | (Monthly) Medical Home Payment PMPM | (Annual**) Performance Based Reimbursement | Possible Total Reimbursement PMPM |
|---|---|---|---|
| Initial 18 Months of operation | $3.00 | $1.00 | $4.00 |
| No Medical Home Recognition | $1.00 | $1.00 | $2.00 |
| Medical Home Recognition at level other than highest | $2.50 | $1.50 | $4.00 |

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| Medical Home recognition at highest level | $3.50 | $1.50 | $5.00 |

*May be amended annually based on national PCMH recognition/certification standards. The Department will also analyze data collected and consider trends identified in the program and may adjust payment scales for future years as appropriate and with an appropriate advanced notice to involved parties.
** The Annual Performance Payment is calculated PMPM for Full Local and Remote Medical Home Counties Members only.

4. Care Coordination Pool Payments.
   a. A care coordination pool is established to provide payment for medically necessary services provided to IowaCare members for continuation of care provided by a participating IowaCare hospital. The Department shall coordinate the operation of the Care Coordination Pool and track associated expenditures. Access to this pool is restricted to Participating IowaCare Hospitals for expenditures for services for any IowaCare member regardless of medical home assignment.
5. Laboratory Test and Radiology Pool Payments.
   a. A funding pool is established to provide payment for medically necessary laboratory tests and radiology services provided to enrolled IowaCare members. The Department shall coordinate the operation of the Laboratory Test and Radiology Pool and track associated expenditures. Access to this pool is restricted to providers designated by the participating Federally Qualified Health Centers for referred members residing in their medical home counties.
6. Peer-to-Peer Consultation Payment
   a. Primary care providers at a Medical Home may have occasion to consult about the care of a patient previously seen at the specific Participating IowaCare Hospital. In order to facilitate this relationship, billing codes have been opened and reimbursement made available for this activity. For purposes of this subsection, "Peer-to-peer consultations" are communication between a primary care provider and another physician, ARNP, or PA, usually a specialist ("consultant"), for the purpose of obtaining the consultant's professional opinion or plan for a specific IowaCare member.
      i. Reimbursement:
         1. Reimbursement for peer-to-peer consultations will be provided to the specialty consultant at the Participating Hospital for online, telephone, and email conferencing. The reimbursement of the Participating Hospital for such consultations will be fulfilled through the Participating Hospital appropriations provided for the IowaCare program. Specifically,
            a. Online evaluations include telemedicine or other means of real-time video conferencing using the internet or other secure electronic connections (does not including

email). These evaluations require the presence and/or participation of the IowaCare member at one end of the communication.

i. Any amount of time. Code 99444, fee $44.37

b. Telephone consultation can be conducted by voice connection alone. Presence and/or participation of the IowaCare member is not required.

i. 5-10 Minutes of medical discussion. Code 99441, fee $20.30

ii. 11-20 Minutes of medical discussion. Code 99442, fee $37.21

iii. 21-30 Minutes of medical discussion. Code 99443, fee $55.25

c. Email correspondence containing medical discussions about an IowaCare patient over a secure electronic connection are billable. Presence and/or participation of the IowaCare member is not required.

i. Any amount of time. Code 99499, fee $20.30.

ii. Peer-to-peer codes must be billed with the UB modifier.

iii. In order for the consultant to submit a claim, the evaluation must not originate from a related service or procedure (including the same type or other type of peer-to-peer consultation) in the previous 7 days by the consultant, or the immediate scheduling of a service or procedure by the consultant or consultant's partners, midlevel providers, or trainees. If the consultant's opinion requires that a treatment plan, other than diagnostic testing, be initiated and evaluated by the consulting physician prior to the availability of appointments by the consultant, the peer-to-peer evaluation may be reimbursed according to the standard scale.

1. Peer-to-peer consultations must be documented in the IowaCare member's medical record for all online, telephone and email encounters by both the primary care provider and the consultant. This documentation may be requested by the Department of Human Services. Failure of the requesting medical home to document the consultation shall not constitute grounds to deny a payment for a consultation documented in a Participating IowaCare Hospital's medical record.
2. When immediate consultation is not available, the Participating IowaCare Hospital is expected to notify the consulting physician and the Medical Home within one business day with an approximate timeline for the consultant's availability for peer-to-peer consultation.
3. If the Participating IowaCare Hospital determines that the consultation is unnecessary, the consulting physician and the Medical Home will be notified within one business day.

7. Management of Payments. The Department will use best efforts to keep all

interested and appropriate parties apprised of programmatic and financial data related to the status of the IowaCare program

## V. Performance Measures

a. The Medical Home shall be eligible for an annual performance payment for achieving medical home performance benchmarks.

b. All data must be reported through the end of the first state fiscal year of participation, June 30, and submitted to the Department by August 1, or the next business day thereafter. Data will be utilized for any member enrolled and assigned. Medical Homes will be expected to meet all criteria (i – ix listed below) to be awarded the additional PMPM payment. Criteria will be reviewed annually. It is expected that over time measurement will move from the process to the outcomes of the process and align with national quality reporting standards.

c. Medical Homes not meeting the full criteria at the end of the first SFY of participation will have the opportunity to state their case and present information as to why they still should receive additional payment, with the Department making all final decisions. Full documentation of an earnest attempt to meet the outlined measures must be provided. Considerations will be given to the quarterly data collected about proportions of members assigned to whom services have not been provided. The Department may choose to interview the Medical Home to confirm reported results.

d. Performance criteria that must be met to obtain the performance incentive payment are as follows:

   a. As reported by each Medical Home, at least 65 percent of members enrolled in the pilot, over the age of 50, should have their colon cancer screening status reviewed on an annual basis. Colon checks could be performed by any method with appropriate follow up based on US Preventive Services Task Force (USPSTF) guidelines, including:
      - Fecal occult blood test
      - Flexible sigmoidoscopy
      - Double contrast barium enema
      - Colonoscopy

   b. As reported by each Medical Home, at least 75 percent of members enrolled in the pilot should have their body mass index (BMI) measured or calculated and recorded in their medical record, and reported to the Department on an annual basis. BMIs should be reported in aggregate to be aware of the status of the population.

   c. Educational and informational printed material provided to the enrolled members should be culturally and linguistically appropriate to the medical home patient population. Each medical home is to report a list of available languages for printed material, samples of a patient medication list, two examples of patient home-bound instructions, and two examples of patient reminder notices. Additional information should be provided on the current process in place to improve this form of communication to patients.

   d. All members referred to a Participating IowaCare Hospital for secondary and/or tertiary care should be tracked via a referral tracking system (either manually

[paper based] or electronically maintained). Each Medical Home is to report on their process for ensuring the referral tracking system and to report any known or suspected failures of tracking.

e. As reported by the Medical Home, an active medication list must be maintained for at least 80% of all members enrolled by having at least one entry (or an indication that the patient is not currently prescribed any medication) recorded.
f. All members enrolled in the Medical Home Pilot are entered into the registry according to their chronic condition(s). Only a Diabetes Registry is required during year one. Each center is to report on their process for ensuring entry into the registry and to report any known or expected failures.
g. As reported by the Medical Home, at least 75 percent of all members enrolled in pilot will have their tobacco use status documented.
h. Each Medical Home is to report the number of members enrolled in the program who have had annual immunizations or there is documentation that immunizations were offered, education provided to member, and member refused.

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| **Care Coordination** | Below are definitions from the Iowa Administrative Code for IowaCare and Iowa Code for Medical Homes.<br><br>(92.1)Provider-directed care coordination services means provider-directed services in a clinical setting aimed at managing all aspects of a patient's care to ensure quality of care and safety. All aspects of care are coordinated by the clinical team under the direction of a physician. The team must include a dedicated care coordinator.<br>[135.158(2)c] Whole Person Orientation. The personal provider is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end-of-life care.<br>[135.158(2)d] Care is coordinated and integrated across all elements of the complex health care system and the patient's community. |
| **Continuity of Care Document (CCD) -** | The CCD document is developed for each member and details important aspects of member's medical needs. This document will be updated and maintained by the medical home and will be updated regularly as a means of communication between the referring provider and the consulting provider. The CCD document, although not universally identified as such, is likely to contain |

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| | elements similar to; Payers, Advance Directives, Support, Functional Status, Problems, Family History, Social History, Alerts (e.g. Allergies, Adverse Events), Medications, Medical Equipment, Immunizations, Vital Signs, Results, Procedures, Encounters, Plan of Care (the HL7/CDA components). The department does not define or enforce the specific elements or format of this document, only the use of a like document is required to satisfy this component of the model. |
| **Local Medical Home County** | A Local Medical Home County is a designated county in which a Medical Home is paid a monthly Medical Home Payment (PMPM) and whose members are considered towards the Performance Based Reimbursement payment. These counties include the county in which the medical home is located and those that are contiguous to the county in which the Medical Home is physically located. |
| **Participating IowaCare Hospital** | A Participating IowaCare Hospital is a hospital designated by the Department that performs secondary and/or tertiary care for IowaCare members assigned to a Medical Home. Participating IowaCare Hospitals are the University of Iowa Hospitals and Clinics (UIHC) and Broadlawns Medical Center. |
| **Personal Treatment Plan (PTP)** | The PTP can be developed from conducting a comprehensive evaluation (CE) of the patient. This document has less structure than a CCD and may read like the plan portion of a progress note. In some instances, a current progress note or the CCD may contain the PTP, which should be noted. Treatment plan should be sent with a referral to provide included, but not limited to the items listed below;<br>• Active diagnostic and therapeutic plans<br>• Plans for future referrals<br>• Contingency plans for treatment or diagnostic failures<br>Recommendations that patients are considering or treatment decisions have not yet been made |
| **Primary Care** | American Academy of Family Physicians<br>Primary care is that care provided by providers specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the |

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| | "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.<br><br>Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal provider often collaborating with other health professionals, and utilizing consultation or referral as appropriate.<br><br>Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care. |
| **Remote Medical Home County** | A Remote Medical Home County is a designated county in which a Medical Home is paid a monthly Medical Home Payment (PMPM) and whose members are considered towards the Performance Based Reimbursement payment, using a different threshold from local Medical Home Counties. The same medical home services are rendered to IowaCare members that reside in a Remote Medical Home County as in a Local Medical Home County. These counties are not contiguous to the county in which the Medical Home is physically located. |
| **Specialty Care** | Johns Hopkins Medicine<br>Definition of Broad Specialty Care: Specialized health care provided by physicians whose training focused primarily in a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics, ophthalmology, and other specialized fields.<br><br>Definition of Tertiary Care: Specialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a center that has personnel and facilities for special |

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| | investigation and treatment. (Secondary medical care is the medical care provided by a physician who acts as a consultant at the request of the primary physician.) |

i. As reported by each Medical Home, at least 70 percent of all eligible women enrolled should have an age appropriate cervical screen or documentation of need for exam.
j. As reported by each Medical Home, at least 80 percent of all enrolled members with a diagnosis of diabetes have had at least one A1C annually.

## VI. PPC-PCMH Scoring

| Level of Qualifying | Points | Must Pass Elements at 50% Performance Level |
|---|---|---|
| Level 3 | 75 – 100 | 10 of 10 |
| Level 2 | 50 – 74 | 10 of 10 |
| Level 1 | 25 – 49 | 5 of 10 |
| Not Recognized | 0 – 24 | <5 |

Levels: If there is a difference in Level achieved between the number of points and "Must Pass," the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" elements, the practice will achieve Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" elements are not recognized.

## VII. Definitions: