Iowa Department of Human Services

Iowa Marketplace Choice Plan 1115 Waiver Application

August 2013

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Introduction

Iowa has a history of health care innovation and commitment to the working poor population. From the IowaCare 1115 demonstration, which was implemented in 2005 and served over 172,000 Iowans with incomes at or below 200 percent of the FPL, to the State Innovation Models grant, which implements statewide multi-payor Accountable Care Organizations (ACOs), Iowa has demonstrated dedication to innovative health care options for low-income populations. Continuing with this history of health care innovation, the Iowa Legislature recently passed the Iowa Health and Wellness Plan. Working in tandem with the advance premium tax credits that will be available in 2014, this legislation will assure universal access to health insurance for all Iowa citizens while promoting private market coverage. The Iowa Health and Wellness Plan will replace the IowaCare 1115 Demonstration waiver and will implement two new 1115 demonstrations that by 2016 will collectively provide coverage to 190,000 adults ages 19 through 64 with income up to and including 133 percent of the FPL[1]. Current members in the IowaCare demonstration with incomes above 133 percent of the FPL will be eligible to receive advance premium tax credits through the Iowa health insurance marketplace (Marketplace).

In May of 2013, the Iowa Legislature passed the Report of the Conference Committee on Senate File 446, which includes the Iowa Health and Wellness Plan. The Iowa Health and Wellness Plan calls for health care coverage for Iowans ages 19 through 64 years-of-age with income not exceeding 133 percent of the federal poverty level (FPL) and consists of three components: (1) the Iowa Wellness Plan demonstration serving eligible individuals with income up to and including 100 percent of the FPL and medically frail eligible individuals with income up to 133 percent of the FPL that promotes coordinated care, managed care, and the development of Accountable Care Organizations (ACOs); (2) the Marketplace Choice Plan demonstration serving non-medically frail individuals with income at 101 percent of the FPL up to and including 133 percent of the FPL by offering premium assistance for eligible individuals to enroll in Qualified Health Plans (QHPs) through the Marketplace; and (3) offering premium assistance for cost-effective employer sponsored insurance (ESI) under Iowa's Health Insurance Premium Payment (HIPP) Program.[2] By implementing two separate 1115 demonstrations and offering the HIPP Program to individuals up to and including 133 percent of the FPL with access to cost-effective ESI coverage, Iowa seeks to promote private market coverage, capitalize on the efficiencies of the Marketplace, and mitigate the challenges of churn for those individuals most likely to become eligible for premium tax credits.

Iowa will seek two 1115 waivers to implement the Iowa Health and Wellness Plan and will modify the HIPP Program as necessary to include coverage for eligible individuals who have access to cost-effective ESI health plans. This 1115 waiver request addresses the Marketplace Choice Plan. Iowa seeks this waiver authority under Section 1115 of the Social Security Act and requests approval of this new demonstration from the Centers for Medicare and Medicaid

[1] With the FPL disregard, 133 percent of the FPL will include individuals with income up to and including 138 percent of the FPL.
[2] With the 5 percent of the of FPL disregard, individuals with income up to 138 percent of the FPL may be eligible.

Services (CMS). A separate 1115 waiver request for the Iowa Wellness Plan is being submitted simultaneously with this 1115 waiver request.

By coordinating with the Marketplace QHPs, the Marketplace Choice Plan creates a private market experience for members, assures access to care, and reduces churn between Medicaid and the Marketplace with the overall goals of increasing access and improving quality of care. Iowa expects that by 2016, there will be 36,134 individuals enrolled in premium assistance through the Marketplace Choice Plan with an additional 17,793 individuals eligible for and enrolled in cost-effective ESI coverage via the HIPP Program. Additionally, the structure of the Marketplace Choice Plan is intended to make the Marketplace and private market more attractive to insurers by providing more covered lives to increase competition resulting in the lowering of health care costs for all Iowa citizens.

As aforementioned, the Marketplace Choice Plan targets individuals ages 19 through 64 who are not eligible for other categories of Medicaid or Medicare, have income at 101 percent of the FPL up to and including 133 percent of the FPL, are not medically frail, and do not have access to cost-effective ESI coverage. Eligible individuals will be screened for access to cost-effective ESI prior to enrollment in the Marketplace Choice Plan. Those individuals with access to a cost-effective ESI health plan will not be enrolled in the Marketplace Choice Plan but will be provided with premium support to access their employer's health plan through Iowa's existing HIPP Program. Additionally, individuals determined eligible for the Marketplace Choice Plan will be screened prior to enrollment to determine if they qualify for medically frail status as described at 42 CFR § 440.315(f) and a retrospective process will be implemented to identify individuals who become medically frail post enrollment. Due to their increased need for specialized medical services and management, individuals who qualify as medically frail will not be eligible for the Marketplace Choice Plan but will, instead, be enrolled in traditional fee-for-service coverage under the Medicaid State Plan with the option to opt-out of the Medicaid State Plan coverage and receive coverage under the Iowa Wellness Plan. The Marketplace Choice Plan ensures the provision of Essential Health Benefits (EHB). In addition, dental benefits, similar to those provided on the Medicaid State Plan, will be provided as a supplement to the EHB benefits.

The Marketplace Choice Plan contains a unique incentive program that is intended to improve the use of preventive services and other healthy behaviors through the elimination of monthly financial contributions for those that complete targeted preventive health services and healthy behaviors. Members will be required to contribute financially toward their health care costs through monthly financial contributions. The required financial contributions are designed to be lesser than or comparable to premium payments for those who receive premium tax credits available in the Marketplace. However, for the first 12 month period of enrollment in the Marketplace Choice Plan, all monthly financial contributions are waived. If members complete key health improvement behaviors in their first 12 months of enrollment, the required financial contributions are waived again for the next 12-month enrollment period. Key health improvement behaviors may include items such as completion of preventive health care and health assessments. Iowa will define the targeted behaviors for each coverage year. Members who continue to complete health improvement behaviors in each 12-month period of enrollment will never be subject to the required monthly financial contribution. The required financial

contributions are the only cost sharing required of Marketplace Choice Plan members other than copayments for non-emergency use of the emergency department. Both the monthly financial contribution and the copayment for emergency use of the emergency department will be waived the first year of the demonstration.

Required financial contributions for members with cost-effective ESI will be phased in over the course of the demonstration and all individuals with income in excess of 50 percent of the FPL made eligible by the Iowa Health and Wellness Plan legislation will be subject to required contributions if they have not completed targeted healthy behaviors and preventive services in the preceding 12-month enrollment period. In addition, if members do not complete the required healthy behaviors and preventative services, they will have the opportunity to request a hardship waiver if they cannot afford to make their monthly contribution.

Pursuant to the Iowa Health and Wellness Plan legislation, this 1115 waiver request is predicated on the enhanced matching rates and funding made available through the Affordable Care Act (ACA). If these enhanced funds are not available, Iowa will withdraw its request and cease program operations.

The Marketplace Choice Plan will be offered across the entire state; however the options offered to members in different areas of the state may vary based on the Marketplace Choice Plan QHP's provider network.

Approval for this initial 1115 waiver is requested for the maximum allowable time of five years (2014-2018).

Program Description and Objectives

CMS Request: Describe premium assistance program you plan to implement in two sentences.

This waiver demonstration will offer coverage for non-medically frail individuals ages 19 through 64 years-of-age with income at 101 percent of the FPL up to and including 133 percent of the FPL who are not eligible for Medicare or comprehensive Medicaid under an existing Iowa Medicaid group and who do not have access to cost-effective ESI coverage. Eligible members will receive coverage though QHPs on the Marketplace. Coverage provided by these Marketplace Choice Plan QHPs will cover all Essential Health Benefits (EHB) and will be at least equivalent to the benefits provided on the commercial market EHB benchmark.

CMS Request: Describe what you are seeking to demonstrate in basic terms.

This 1115 waiver request seeks CMS approval to implement an innovative demonstration that supports private coverage through utilization of the Iowa Marketplace to provide greater access to health care, increased continuity of care and insurance coverage, less "churn" related to insurance coverage, and lower health care costs.

The structure of the Marketplace Choice Plan provides greater access to health care in two significant ways. First, the Marketplace Choice Plan provides coverage to a population that has

not received statewide access or comprehensive benefits in the past. Second, by placing members in the Iowa Marketplace, members will have greater access to health care providers, based upon the assumption that more health care providers will be enrolled in the Iowa Marketplace Choice Plan QHPs than traditional fee-for-service Medicaid due to the anticipated higher reimbursement rates.

Next, the Marketplace Choice Plan is expected to decrease the amount of insurance coverage "churn" for members, which will result in greater continuity of care. Marketplace Choice Plan members, those with income at 101 percent of the FPL up to and including 133 percent of the FPL, experience more frequent fluctuations in income than the population enrolled in the Iowa Wellness Plan (individuals with income at or below 101 percent of the FPL). Therefore, Marketplace Choice Plan members are more likely to move between eligibility for Medicaid and the advanced premium tax credits on the Iowa Marketplace. By providing coverage through the Iowa Marketplace, members will be able to maintain their QHPs even if their income increases and they are no longer eligible for the Marketplace Choice Plan. This creates a more stable coverage experience, increased continuity of care, and improved quality of care for Marketplace Choice Plan members.

Lastly, the Marketplace Choice Plan is designed to lower health care costs for all Iowans. The Marketplace Choice Plan brings more covered lives to the Marketplace, which is intended to increase competition in the Marketplace. Bringing more competition into the Marketplace and spreading health care costs among a larger population should result in more choices and lower premium rates for all Iowans.

Eligibility

Eligibility criteria for the Marketplace Choice Plan is designed to place the majority of the eligible individuals in the private insurance market, so that such individuals receive access to much needed care but experience less "churn" than they would experience in traditional fee-for-service Medicaid coverage. The Marketplace Choice Plan is targeted at non-medically frail individuals with income at 101 percent of the FPL up to and including 133 percent of the FPL who are the most likely to transition to Marketplace coverage. It strives to provide consistent policy and benefits between Marketplace Choice Plan coverage provided through this demonstration and coverage on the Marketplace for individuals eligible for premium tax credits and cost sharing reductions.

The Marketplace Choice Plan is targeted specifically at a sub-set of the ACA Adult Group, which includes individuals who are 19 through 64 years-of-age with income at 101 percent of the FPL up to and including 133 percent of the FPL, who are United States' citizens or documented, qualified aliens, who do not have access to cost-effective ESI coverage,[3] who are not medically frail, and who are not eligible for Medicare or comprehensive Medicaid under an existing Iowa Medicaid group. Eligibility for the Marketplace Choice Plan will be determined using the modified adjusted gross income (MAGI) methodology. Participation in the Marketplace Choice Plan will

[3] Those with access to cost-effective ESI will be covered through Iowa's HIPP Program on the Medicaid State Plan.

be the only option for individuals who fall in this eligibility group, unless eligible individuals have access to cost-effective ESI coverage or are medically frail. Eligible individuals will be given a choice of at least two QHPs participating in the Marketplace Choice Plan. For the initial demonstration years, two QHP issuers have filed statewide QHPs.

Maintaining the commitment to leverage the private insurance market, eligible individuals, who have access to cost effective ESI health plans, will not be enrolled in the Marketplace Choice Plan. Instead, Iowa will provide premium assistance to these individuals to enroll in the ESI health plans through the HIPP Program. In addition, individuals who meet the definition of medically frail, as described below, will not be eligible for the Marketplace Choice Plan but will, instead, be provided with coverage under the Medicaid fee-for-service State Plan or the Iowa Wellness Plan, at the member's option, where the benefits are more appropriately suited to meet their needs.

CMS Request: List the population(s) that will be included in the demonstration in the following chart.

Marketplace Choice Plan Population

Table 1: Eligibility

Description	Income	Age	Exceptions
The Adult Group – Marketplace Choice	*101 percent of the FPL to 133 percent of the of the FPL*	19 through 64	*Medically Frail, 42 CFR 440.315(f)* *Those eligible for cost-effective ESI.*

CMS Request: Describe any population or subset of a population that will be allowed to opt in and opt out of premium assistance demonstration and the process for operationalizing the opt in and opt out.

In order to maintain the integrity and cost-effectiveness of the Marketplace Choice Plan, members will not be provided a choice as to whether they will opt-in or opt-out of the Marketplace Choice Plan into another Medicaid coverage option. However, eligible individuals will be given the choice of at least two Marketplace Choice Plan QHPs available in their region. Individuals, who do not select a Marketplace Choice Plan QHP, will be auto-assigned on an alternating selection basis. In future years, Iowa may modify its auto-assignment logic to favor Marketplace Choice Plan QHPs based on quality ratings, cost, geography, and other factors.

Medically frail individuals with income at 101 percent of the FPL up to and including 133 percent of the FPL will not be eligible for the Marketplace Choice Plan but will, instead, receive traditional fee-for-service coverage under the Medicaid State Plan or the Iowa Wellness Plan where a more appropriate offering of services is available for the management of complex

mental health and medical conditions. Medically frail individuals will not have the opportunity to opt-in to the Marketplace Choice Plan QHPs.

In addition, individuals who are eligible for the Marketplace Choice Plan but have access to cost-effective ESI coverage will not be placed in the Marketplace Choice Plan but will receive premium assistance through the HIPP Program to purchase the ESI coverage. This population will also not be provided the opportunity to choose between their ESI coverage and Marketplace Choice Plan coverage.

Moreover, members who become eligible for other categories of Medicaid, for example an individual who becomes disabled after enrollment, will be able to be reassigned to coverage in other applicable Medicaid categories.

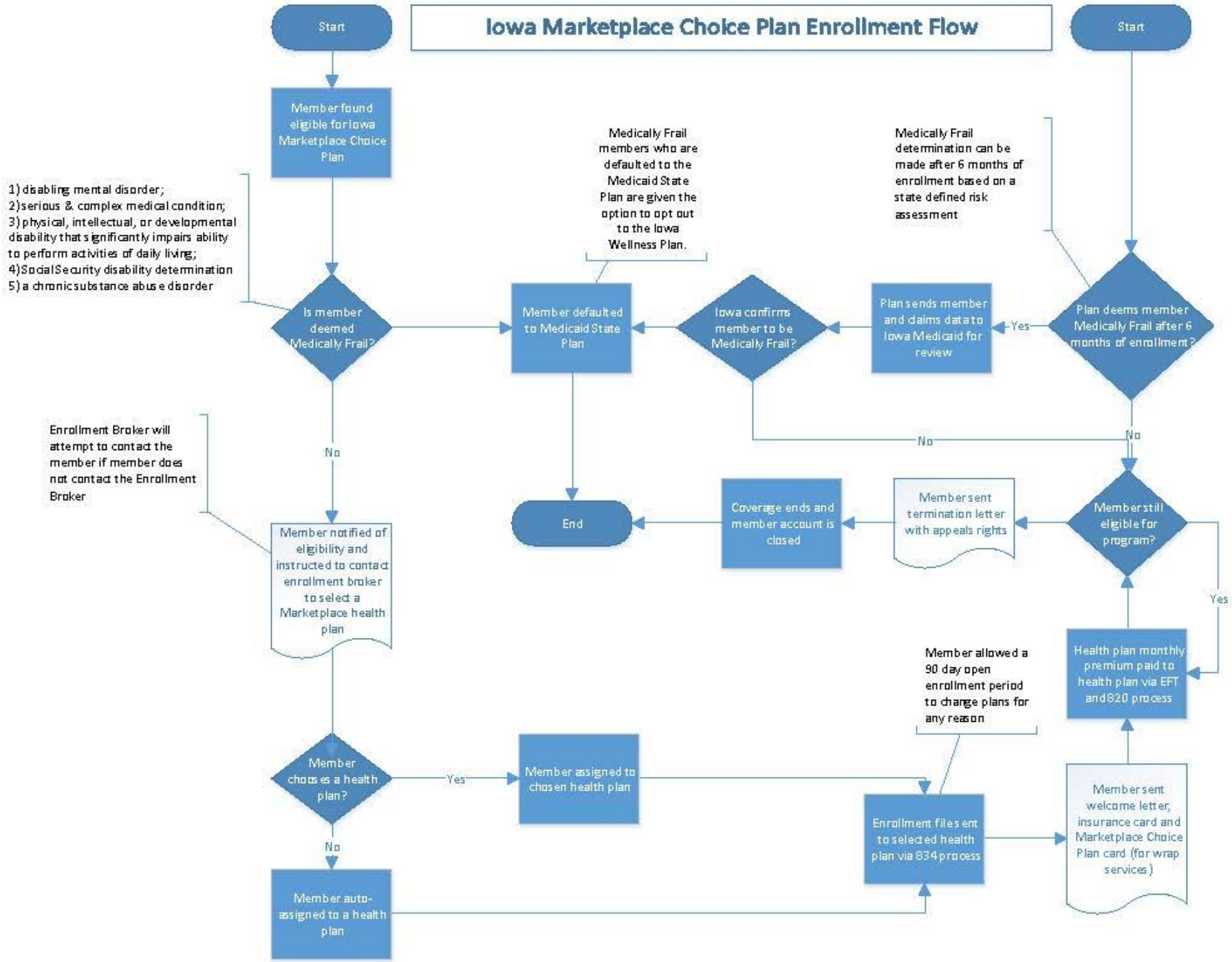
Enrollment

CMS Request: Describe the enrollment process the state will use to enroll individuals eligible to participate in this program, including an assurance that the medically frail will not be enrolled in an alternative benefit plan.

Iowa's goal is to keep enrollment simple and streamlined for Marketplace Choice Plan members. Individuals will begin applying for the Marketplace Choice Plan on October 1, 2013 by utilizing the following process:

- Individuals will submit a single streamlined application electronically, via phone, by mail, or in-person.
- The Iowa Department of Human Services will perform the Medicaid eligibility determination.
- Once individuals have been determined eligible for coverage under the Marketplace Choice Plan, they will receive notification of their eligibility for Medicaid. A subsequent notice will convey that the individual is eligible for the Marketplace Choice Plan, will inform the individual of their Marketplace Choice Plan QHP options, and will invite the individual to select a marketplace QHP through the completion of an included form or by calling the Medicaid enrollment broker, if they require assistance. The notice will also indicate the Marketplace Choice Plan QHP to which the individual will be auto-assigned if they do not make a selection within the allotted time period. The individual will have a certain amount of time in which to change their QHP selection or auto-assignment and then will remain in the selected or auto-assigned Marketplace Choice Plan QHP for the remainder of the annual enrollment period.
- The MMIS will capture the eligible individual's Marketplace QHP selection information and will transmit the enrollment transactions to the carriers.
- Carriers will issue insurance cards to enrolled members.
- MMIS will pay premiums on behalf of members directly to the carriers.
- MMIS premium payments will continue until the participant is determined to no longer be eligible for the Marketplace Choice Plan, the participant selects an alternative plan at renewal or during a special enrollment period, or the participant is determined to be medically frail or obtains access to cost-effective ESI coverage.

This enrollment process is illustrated on the following page.


Iowa Marketplace Choice Plan Enrollment Flow
Start
Member found eligible for Iowa Marketplace Choice Plan
1) disabling mental disorder;
2) serious & complex medical condition;
3) physical, intellectual, or developmental disability that significantly impairs ability to perform activities of daily living;
4) Social Security disability determination
5) a chronic substance abuse disorder
Is member deemed Medically Frail?
Medically Frail members who are defaulted to the Medicaid State Plan are given the option to opt out to the Iowa Wellness Plan.
Member defaulted to Medicaid State Plan
Iowa confirms member to be Medically Frail?
Plan sends member and claims data to Iowa Medicaid for review
Yes
Medically Frail determination can be made after 6 months of enrollment based on a state defined risk assessment
Plan deems member Medically Frail after 6 months of enrollment?
Start
No
No
Enrollment Broker will attempt to contact the member if member does not contact the Enrollment Broker
Member notified of eligibility and instructed to contact enrollment broker to select a Marketplace health plan
End
Coverage ends and member account is closed
Member sent termination letter with appeals rights
Member still eligible for program?
Yes
Member allowed a 90 day open enrollment period to change plans for any reason
Health plan monthly premium paid to health plan via EFT and 820 process
Member chooses a health plan?
Yes
Member assigned to chosen health plan
No
Member auto-assigned to a health plan
Enrollment files ent to selected health plan via 834 process
Member sent welcome letter, insurance card and Marketplace Choice Plan card (for wrap services)

In order to prevent administrative and operational issues and allow ease of enrollment for individuals, the Marketplace Choice Plan will have year-round enrollment in lieu of a specified enrollment time period. After enrollment in a plan, members will have a 90 day period to change plans for any reason. Outside of this 90 day period members are required to stay with their plan for the remainder of their 12 month enrollment period unless they experience a qualifying event.[4]

In addition, members will be provided a 60-day grace period in which to pay all outstanding required financial contributions in full (see Cost Sharing section for more information). Members, who do not pay outstanding financial contributions in full during this time frame, will be terminated from the Marketplace Choice Plan. Individuals who have been terminated from the Marketplace Choice Plan for non-payment of required contributions must then reapply for the program and be determined eligible to receive coverage. All individuals are exempt from paying required financial contributions in the first year, and individuals may maintain their exemption from paying the required contribution by completing health improvement behaviors including, but not limited to, preventive services. Termination from the Marketplace Choice Plan for non-payment of required financial contributions will only impact individuals who do not complete health improvement behaviors in the prior year and who are more than 60 days late on payments of their required financial contributions.

Required financial contributions for members with cost-effective ESI will be phased in over the course of the demonstration and all individuals with income in excess of 50 percent of the FPL made eligible by the Iowa Health and Wellness Plan legislation will be subject to required contributions if they have not completed targeted healthy behaviors and preventive services in the preceding 12 month enrollment period.

CMS Request: Describe the process for determining, via your alternative cost-effectiveness model, which plans will be available to individuals in premium assistance.

Because Iowa is covering all costs in a member's first year and each subsequent year that health improvement behaviors are complete, the Marketplace Choice Plan will offer members a choice among QHPs participating in the Marketplace Choice Plan at the silver level with the 100 percent of the actuarial value variation, equivalent to the American Indiana Alaska Native plan variation.

QHPs will be certified through the Iowa Insurance Division's QHP certification process. As noted above, Marketplace Choice Plan members will be able to choose among those high-value silver plans available in their geographic region that are participating in the Marketplace Choice Plan. As part of the QHP certification process, QHPs with premiums that are determined to be outliers will be identified and subject to additional scrutiny which will help ensure that members choose among only cost-effective QHPs. In the subsequent years of the demonstration, Iowa will review carrier competition and premiums and may establish more selective criteria for QHP eligibility for the Marketplace Choice Plan to ensure both beneficiary choice and cost-effective purchasing that meets the terms and conditions of this waiver.

[4] Qualifying events for the Marketplace Choice Plan are the same events that trigger a special enrollment period in the Marketplace.

CMS Request: Describe the process that individuals will use to choose a plan.

The Marketplace Choice Plan provides a simple, streamlined process for Marketplace QHP selection and provides eligible individuals with the appropriate support and assistance to help facilitate selection and enrollment through an enrollment broker. Iowa will provide immediate access and continuity of care by ensuring that individuals, who have been determined eligible for the Marketplace Choice Plan but who have not yet been enrolled in a Marketplace Choice Plan QHP, receive fee-for-service coverage under the Iowa Wellness Plan if they seek health care services during the time period before QHP selection. The provision of this fee-for-service coverage is not expected to last more than 45 days.

To initiate the selection and enrollment process, Iowa will send an enrollment notice to eligible individuals, that will include: 1) instructions to contact a Medicaid enrollment broker for assistance with Marketplace Choice Plan QHP selection or mail a form containing the individual's selection; and 2) information concerning auto-assignment to a Marketplace Choice Plan QHP, if they do not make a plan selection within a specified time frame. After selection of or auto-assignment to a QHP, Iowa will send members a second notice informing them of their enrollment in one of the Marketplace Choice Plan QHPs. The individual will have a certain amount of time in which to change their QHP selection or auto-assignment and then will remain in the selected or auto-assigned Marketplace Choice Plan QHP for the remainder of the annual enrollment period. During the first year of enrollment, Iowa will auto-assign eligible individuals, who do not make a selection, to Marketplace QHPs using an alternating methodology. After the first year of the demonstration, Iowa may develop an auto-assignment methodology based on quality, cost, geography, or other factors.

Screening for Medical Frailty

Due to the complexity of medical management and needs, individuals who meet the medically frail definition will not be eligible for the Marketplace Choice Plan but will, instead, receive fee-for-service coverage under the Medicaid State Plan or the Iowa Wellness Plan. An individual will be considered medically frail if they have any one or any combination of the following: 1) disabling mental disorder; 2) serious and complex medical condition; 3) physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living; 4) a disability determination based on Social Security criteria; or 5) a chronic substance use disorder.

Iowa will implement a robust three-pronged approach with a combination of retrospective and prospective screening processes to ensure identification of medically frail individuals.

- First, Iowa will provide education and outreach regarding medical frailty to navigators, certified application counselors and other individuals assisting with Medicaid applications. Education and outreach on the medically frail will also be provided to community mental health providers and other health care providers who treat the most medically vulnerable patients so that they understand the process and the need to identify individuals who meet the definition of medically frail.

- Second, Iowa will utilize a self-attestation method of screening via affirmative answers to two questions on the single-streamlined application regarding receipt of Social Security income and/or having a physical, mental, or emotional health condition that causes limitations in activities of daily living. If an applicant answers affirmatively to either or both questions, they will be considered as potentially medically frail and will be targeted for further screening. Iowa is in the process of developing a questionnaire, with consideration given to the contents of the CMS medically frail notice, which will be sent to those individuals who answer affirmatively to one or both of the aforementioned application questions. This questionnaire will assist with the self-identification of medically frail. In future years, the medically frail questionnaire may be available online to streamline the eligibility process for members.
- As a final measure, Iowa will identify health conditions and diagnosis codes which qualify an individual for medically frail status. There will be a process to identify medically frail members currently enrolled with health plans, PCPs, or ACOs through actuarial identification or another method; these medically frail members will be provided with the State Plan coverage option with the opportunity to elect Iowa Wellness Plan coverage. Members may be reclassified as medically frail at any time during their coverage period. Iowa will annually rescreen members during the redetermination process. In addition, Iowa will consider development of a process to monitor claims experience to identify false positives for persons who were initially determined medically frail but, as evidenced by processed claims, prove not to be medically frail.

Iowa will continually monitor and evaluate the process for identifying the medically frail, so that enhancements and modifications can be implemented as needed to assure that medically frail individuals are appropriately placed in the Medicaid State Plan or, at the individual's option, placed in the Iowa Wellness Plan.

Screening for Employer Sponsored Insurance (ESI)

As part of the Iowa Health and Wellness Plan legislation, which promotes greater health care coverage through the utilization of the private market, Iowa will also screen individuals for access to a cost effective ESI health plan upon application and annual re-determination. Individuals who have access to cost-effective ESI coverage will not be placed in or will be removed from the Marketplace Choice Plan and will be required to enroll in the cost-effective ESI health plan. Iowa will then provide premium assistance for the cost-effective ESI health plans for eligible individuals under the HIPP Program. If the cost-effective ESI health coverage is terminated or changes in a manner that makes it no longer cost-effective, the individual will then be enrolled in the Marketplace Choice Plan. In future years of the demonstration, eligible individuals, who are enrolled in cost-effective ESI coverage, will be subject to the cost sharing provisions that are included in the Marketplace Choice Plan as set forth in the Cost Sharing section below.

Future Medicaid Enrollment

Individuals enrolled in the Marketplace Choice Plan, who become eligible for another Medicaid eligibility category per a redetermination, will be transferred to that category.

Current IowaCare Members

For purposes of creating the least amount of disruption in coverage for current IowaCare members, Iowa will notify the current IowaCare members of the opportunity to apply for enrollment in the Iowa Wellness Plan and Marketplace Choice Plan prior to the IowaCare expiration date of December 31, 2013. Iowa will perform member outreach and education for current IowaCare members regarding these options through a third party administrator.

Expected Enrollment

Estimated enrollment in the Marketplace Choice Plan assumes that for the population with incomes from 101 percent of the FPL up to and including 133 percent of the FPL, 18 percent of the of the IowaCare population and 7 percent of the of other eligible populations will be determined to be medically frail. It is assumed that all current IowaCare members with income from 101 percent of the FPL up to and including 133 percent of the FPL will participate in the coverage option and that 60 percent of the other eligible individuals will enroll in the first year, and 90 percent will enroll in year two. Ten percent of the eligible individuals are expected not to enroll. Enrollment projections include a 1.5 percent of the natural growth rate. Estimates of the numbers of individuals who will enroll by year in the Marketplace Choice Plan are contained in Table 2 below. Though they will not be enrolled on the Iowa Marketplace Choice Plan, this table also provides estimates for the individuals with income from 101 percent of the FPL up to and including 133 percent of the FPL who will become eligible for the HIPP Program due to the implementation of the Iowa Health and Wellness Plan.

Table 2: Projected Marketplace Choice Plan and Cost-effective ESI Enrollment

	2014	2015	2016	2017	2018
Marketplace Choice Plan (QHP)	24,891	35,600	36,134,	36,676	37,226
Total	**24,891**	**35,600**	**36,134**	**36,676**	**37,226**
HIPP Enrollment (Cost-effective ESI)	**11,514**	**17,530**	**17,793**	**18,060**	**18,331**

Benefits

CMS Requirement: List the alternative benefit plan that aligns with the plans offered by the Qualified Health Plan(s).

The Marketplace Choice Plan assures coverage for Iowa's commercial market Essential Health Benefit (EHB) benchmark package through the Marketplace Choice Plan QHPs. The Marketplace Choice Plan QHPs will cover all required EHB services, as required by federal law. Dental services similar to those provided on the Medicaid State Plan will be provided via a contracted commercial dental product to Marketplace Choice Plan members, medically frail individuals, who have coverage under either the Medicaid State Plan or the Iowa Wellness Plan, and those individuals with cost-effective ESI coverage, who do not have dental benefits through their ESI health plan.

As an Alternative Benefit Plan (ABP), this waiver requests the 1937 Secretary Approved Coverage option for benefits indexed to the commercial market EHB benchmark. Additional details regarding the ABP benefits will be included in Iowa's ABP Medicaid State Plan Amendment. Iowa will also explore covering additional Medicaid populations through the ABP to align benefits with populations and ensure families are on the same plan network.

A summary of the benefits available in Iowa's commercial market benchmark plan can be accessed at: http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/iowa-ehb-benchmark-plan.pdf.

Please see Table 3 below for a description of Iowa's EHB benchmark plan covered benefits and Table 4 below for a description of the non-covered benefits.

Table 3: Iowa Essential Health Benefit Benchmark Plan Covered Benefits

Benefit	Description of Amount, Duration and Scope
EHB Category: Ambulatory Patient Services	
Primary Care Physician Services	Covered.
Specialty Physician Visits	Covered.
Home Health Services	Covered.
Chiropractic Care	Covered.
Infertility Diagnoses and Treatment	Covered, limited to diagnoses. Artificial insemination and in vitro fertilization excluded.
Outpatient Surgery	Covered.
Second Surgical Opinion	Covered.
Allergy Testing	Covered.
Chemotherapy	Covered.
IV Infusion Services	Covered.
Radiation Therapy	Covered.
Dialysis	Covered.
Dental Services – Accidental Only	Covered for dental services resulting from accident. Care must be completed within 12 months of injury.
EHB Category: Emergency Services	
Emergency Room Services	Covered. Non-emergency visits to the emergency department subject to $10 copayment after initial demonstration year.

Benefit	Description of Amount, Duration and Scope
Emergency Transportation-Ambulance and Air Ambulance	Covered.
Urgent Care/Emergency Clinics (non-hospital facilities)	Covered.
EHB Category: Hospitalization	
General Inpatient Hospital Care	Covered.
Inpatient Physician Services	Covered.
Inpatient Surgical Services	Covered.
Non-Cosmetic Reconstructive Surgery	Covered.
Transplants	Covered.
Bariatric Surgery	Covered.
Congenital Abnormalities Correction	Covered.
Anesthesia	Covered.
Hospice Care	Covered.
Hospice Respite	Covered. Limited to 15 days per lifetime for inpatient and outpatient respite care. Must be used in increments of not more than 5 days at a time.
Skilled Nursing Facility	Covered, limited to 90 days.
EHB Category: Mental Health Behavioral Health Substance Abuse	
Mental/Behavioral Health Inpatient Treatment	Covered. Required to be at parity. Medically frail individuals will be covered through the Medicaid State Plan or Iowa Wellness Plan.
Mental/Behavioral Health Outpatient Treatment	Covered. Required to be at parity. Medically frail individuals will be covered through the Medicaid State Plan or Iowa Wellness Plan.
Substance Abuse Inpatient Treatment	Covered. Required to be at parity. Medically frail individuals will be covered through the Medicaid State Plan or the Iowa Wellness Plan.

Benefit	Description of Amount, Duration and Scope
Substance Abuse Outpatient Treatment	Covered. Required to be at parity. Medically frail individuals will be covered through the Medicaid State Plan or Iowa Wellness Plan.
EHB Category: Prescription Drugs	
Prescription Drugs	Covered.
EHB Category: Rehabilitative and Habilitative Services and Devices	
Physical Therapy, Occupational Therapy, Speech Therapy	Covered.
Durable Medical Equipment	Covered.
Prosthetics	Covered.
EHB Category: Laboratory	
Lab Tests	Covered.
X-Rays	Covered.
Imaging- MRI, CT, and PET	Covered.
Sleep Studies	Covered.
Diagnostic Genetic Tests	Covered.
Pathology	Covered.
EHB Category: Preventive Care	
Preventive Care Services	ACA required preventive services covered.[5]
Nutritional Counseling	Covered as related to diabetes education.
Other Benefits	
Dental Services	Adult dental not covered on commercial EHB. Will be provided to Marketplace Choice Plan Members outside of QHP coverage via a commercial dental product.

Table 4: Iowa Essential Health Benefits Benchmark Plan Non-Covered Benefits

Benefit	Description of Amount, Duration and Scope
Acupuncture	Not Covered.
Vision – Exam	Not Covered.
Vision Services - eyeglasses	Not Covered.

[5] Includes services with an "A" or "B" rating from the United States Preventive Task Force, immunizations recommended by the Centers for Disease Control and Prevention, and additional preventive care screenings for women as provided in the Health Resources and Services Administration guidelines.

Nursing Facility Services	Not Covered past 90 day limit.
Residential Services	Not Covered.
Non-emergency Transportation Services	Not Covered.
EPSDT	Not Covered.
Hearing Aids	Not Covered.
Other	Not Covered.

CMS Request: List the benefits that will be included for the Medicaid benefits wrap.

Based upon the unique structure of the Marketplace Choice Plan, Medicaid wrap benefits are not necessary for members. The Marketplace Choice Plan QHPs provide the required EHBs to members. This ensures that the members receive comprehensive health care services, and the Marketplace Choice Plan will provide its members with dental benefits via a contracted commercial plan. Moreover, if Iowa was not expanding its Medicaid program, the Marketplace Choice Plan members would be eligible for advance premium tax credits and cost sharing reductions in the Iowa Marketplace, and the Marketplace QHPs would not provide wrap around coverage for these benefits.

Individuals, who would utilize Medicaid wrap benefits (*e.g.* habilitation and mental health services), will be classified as medically frail and will not be eligible for the Marketplace Choice Plan. Instead, such individuals will receive traditional fee-for-service coverage through the Medicaid State Plan or coordinated care through the Iowa Wellness Plan, which ensures that this population obtains the specialized services required for their complex medical needs.

Iowa seeks a waiver for early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals 19 to 21 years-of-age and non-emergency transportation services. Although Iowa seeks a waiver of EPSDT services, the only EPSDT services that will not be provided to Marketplace Choice Plan members are vision and hearing aids due to the provision of screening and testing via the QHP preventative services requirement and the provision of dental services via the commercial dental plan. In addition, the waiver of vision services, hearing aids, and non-emergency transportation services assures consistency with the Marketplace QHPs, based upon the fact that vision benefits and non-emergency transportation services are not provided to Marketplace private members receiving premium tax credits and cost sharing reductions. Moreover, ensuring consistency with the Marketplace QHPs will assist in the reduction of the impact of churn if these individuals experience income fluctuations and become eligible for advanced premium tax credits or cost sharing reductions.

CMS Request: Describe the process that will be used to advise individuals about obtaining Medicaid wrap benefits.

Wrap around benefits are not necessary for the Marketplace Choice Plan due to the Marketplace Choice Plan QHPs providing the required EHBs to members. Medically frail

members most likely to need enhanced benefits will be covered on the Medicaid State Plan or the Iowa Wellness Plan; those members covered by the Marketplace Choice Plan will be a population similar to low-income individuals covered by the Marketplace QHPs who may be eligible to receive advanced premium tax credits and cost sharing reductions.

CMS Request: Describe how individuals will obtain the Medicaid wrap benefits.

Wrap around benefits are not necessary for the Marketplace Choice Plan due to the Marketplace Choice Plan QHPs providing the required EHBs to members. Waivers are requested for the requirement to offer EPSDT and non-emergency transportation. However, individuals who would benefit from Medicaid services, such as habilitation services, will still receive such services, as medically frail individuals will be defaulted to enrollment in the Medicaid State Plan along with the option to opt out and obtain coordinated care under the Iowa Wellness Plan. By enrolling individuals with a medically frail status in the Medicaid State Plan with the choice to opt out and receive coverage through the Iowa Wellness Plan, Iowa assures that these individuals receive the needed services without Medicaid wrap services being provided through the Marketplace Choice Plan QHPs. In addition, a screening process will be developed to identify individuals with complex medical conditions who require increased care coordination and may qualify as medically frail and be able to receive services on the Medicaid State Plan.

CMS Request: Describe what measures the state will use to determine that eligible individuals are receiving Medicaid wrap benefits.

Wrap around benefits are not necessary for the Marketplace Choice Plan due to the Marketplace Choice Plan QHPs providing the required EHBs to members. However, individuals, who meet the definition of medically frail and would utilize such services, will be defaulted to enrollment in traditional fee-for-service coverage under the Medicaid State Plan.

CMS Request: Provide an assurance that individuals who meet the exemption criteria specified in section 1937 are given a choice between the benefit package subject to section 1937 requirements and the benefit package provided under the state's approved Medicaid state plan, which is not subject to section 1937 requirements.

Due to their complex medical needs and required services, any individuals, who meet the definition of medically frail (1937 exempt), will not be eligible for the Marketplace Choice Plan, Instead, such individuals will be automatically enrolled in fee-for-service coverage via the Medicaid State Plan with the option to opt out of the Medicaid State Plan coverage and receive coverage under the Iowa Wellness Plan.

CMS Request: Provide an assurance of adherence to all requirements in section 1937 of the Social Security Act (the Act).

Please see the Benefit details beginning on page 14 for details of meeting the requirements of the Alternative Benefits Plan (ABP) and the process describing the screening for medical frail on page 11 assuring that the Marketplace Choice Plan meets the requirements to not mandatorily enroll the medically frail into an ABP.

Delivery System

The Marketplace Choice Plan implements an innovative health care delivery system by leveraging Marketplace QHPs for the purpose of providing health care coverage for low-income individuals. Leveraging Marketplace QHPs not only increases access to much-needed care but also brings more covered lives to the private market resulting in greater quality, efficiencies, and cost-savings for all Iowans.

The Marketplace Choice Plan strengthens Iowa's health care delivery system in three significant ways. First, members in the Marketplace Choice Plan are the most likely to churn between the Marketplace and Medicaid. The provision of coverage through the Marketplace QHPs provides continuity of care for individuals who, due to fluctuations in income, are most likely to transition from the Marketplace Choice Plan to the Iowa Marketplace. By providing these individuals coverage through the Iowa Marketplace, they will experience greater continuity of care. If their income fluctuates and they churn from the Marketplace Choice Plan to the Iowa Marketplace they will be able to maintain their same QHPs and providers. Second, the addition of the Marketplace Choice Plan members to the private market significantly increases the number of patients for which the Marketplace QHP providers are responsible. This, in turn, increases the providers' accountability regarding both cost and quality, which will most likely result in improved health care outcomes. Third, placing the Marketplace Choice Plan members in the Marketplace QHPs increases their access to health care providers. Due to greater reimbursement rates under the Marketplace health plans, as compared to traditional Medicaid reimbursement rates, more providers are likely to enroll in the Marketplace QHPs than in the Medicaid program; thus, creating greater accessibility and improved quality health outcomes for Marketplace Choice Plan members.

The aforementioned factors, in aggregate, will improve quality, promote access, and reduce health care costs for all Iowan citizens, regardless of the underlying subsidy for their health coverage. In addition, all Medicaid beneficiaries, including those with fee-for-service coverage under the Medicaid State Plan, will experience greater access to care by dispersing the growing Medicaid population across a broader network of health care providers.

Managed Care

Because the Marketplace Choice Plan is utilizing premium assistance to purchase coverage in Marketplace QHPs, and not Medicaid managed care plans, to deliver benefits, the Medicaid managed care regulations do not apply to the Demonstration. However, Iowa has provided additional detail and context throughout this 1115 waiver request that align with the Medicaid managed care requirements, such as mandatory enrollment and choice of QHPs. Marketplace Choice enrollees will be provided a carved-out commercial market adult dental benefit that will be provided on a capitated Managed Care basis.

Choice of QHP, Access to Care, and Network Adequacy

Through Iowa's plan management process, Iowa will assure that Marketplace Choice Plan members will be able to choose from among participating high-value silver QHPs offered in each service/rating area of the State. In development of this waiver request, Iowa has reached out to the Iowa Marketplace QHPs and began discussions around covering Marketplace Chocie enrollees. These early discussions will help assure choice for Marketplace Choice enrollees. Additionally, Iowa insurance regulators will evaluate network adequacy, including Marketplace Choice Plan QHP compliance with the ACA's Essential Community Provider network requirements, as part of the QHP certification process. As a result, Marketplace Choice Plan members will have access to the same networks as individuals who purchase coverage in the individual market, ensuring compliance with the requirement found in Section 1902(a)(30)(A) of the Social Security Act that Medicaid beneficiaries have access to care comparable to the access the general population in the geographic area has.

CMS Request: Describe the health care delivery system individuals will use to obtain the Medicaid wrap benefits.

No Medicaid wrap benefits will be provided for this population. Marketplace Choice Plan members will receive coverage for dental services but these services will not be provided as wrap around services through the Medicaid State Plan. Instead, members will be enrolled in a commercial dental plan. Enrollment in a commercial dental plan will increase members' access to dental services as reimbursement for services under these plans will most likely be greater than reimbursement under the Medicaid State Plan dental benefit. Dental services will also be provided via the contracted commercial dental plan to the medically frail population, who receive coverage under either the Medicaid State Plan or the Iowa Wellness Plan, and individuals with cost-effective ESI coverage, who do not have dental coverage under their ESI health plan.

Iowa has requested waivers for other wrap services including non-emergency transportation and EPSDT. All other benefits potentially subject to wrap around services are provided sufficiently through the Marketplace Choice Plan QHPs.

Medically frail individuals who may need access to wrap services including 1915(i) habilitation services will not be eligible for the Marketplace Choice Plan. These individuals will be defaulted to enrollment in the Medicaid State Plan and will be able to opt out to obtain coverage on the Iowa Wellness Plan.

CMS Request: Provide an assurance of an individual's choice of plan.

Marketplace Choice Plan members will be offered, at a minimum, two 100 percent actuarial value QHPs offered on the Marketplace to the American Indian and Alaska Native populations. Members will be informed of their Marketplace QHP choices and instructed on how to select their choice of QHP. Iowa will also remind members of their choices via their renewal notice and provide members the opportunity to change Marketplace QHPs at re-enrollment.

Marketplace QHP Appeals

Under the Marketplace Choice Plan, members will use the Marketplace Choice Plan QHP appeals process for all coverage and provider access decisions and will use Iowa's Medicaid appeals process for all eligibility decisions, including decisions related to the payment of

required financial contributions. All Marketplace QHPs must comply with federal standards governing internal insurance coverage appeals. Additionally, all Marketplace Choice Plan QHPs must comply with state standards governing external review of insurance coverage appeals.

Under Iowa's external review process for health care coverage decisions, claims may be eligible for an external review if the claim was partially or completely denied because the health care service does not meet the Marketplace Choice Plan QHP's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. Claims may also be eligible if the partial or complete denial of coverage is based on the determination that the health care service or treatment is experimental or investigational.

If a member exhausts his or her internal appeal options with the Marketplace Choice Plan QHP and the claim denial is upheld, the QHP is required to notify the member of the right to request an external review. The Marketplace Choice Plan QHP also needs to provide the member with the procedures and applicable forms for each type of claim denial. All requests for external review will be submitted to the Commissioner of the Iowa Insurance Division.

If the Commissioner decides that a claim is eligible for external review, the claim will be assigned to an independent review organization. The review organization will make a final decision within 40 or 45 days of the Commissioner's receipt of the request. Expedited reviews are available if a member needs an immediate review because of the severity of the medical condition or urgent need for service. A final decision for an expedited review will be within 3 or 7 days.

If the independent review organization overturns the Marketplace Choice Plan QHP's decision, the QHP is required to immediately approve the coverage that was originally denied. If the independent review organization upholds the QHP's decision, the member may file a request for review by the appropriate district court.

Waiver and Expenditure Authority

CMS Request: List the specific waiver and expenditure authorities that the state believes to be necessary to authorize the demonstration. This will include freedom of choice to the extent necessary to enable the state to restrict the delivery system to the choice of two QHPs under section 1902(a)(23)(A) of the Social Security Act.

Please see Table 5 below for a description of the waiver authority requests and the rationale for the waiver authority requests for this 1115 waiver application.

Table 5: Waiver Authority Requests and Rationale

Waiver Authority	Use for Waiver	Rationale for Waiver Request
§ 1902(a)(1) Statewideness/ Uniformity	To the extent that a Marketplace QHP may not be offered state wide through the duration of the demonstration period, to allow Marketplace QHP options for	This waiver authority will allow the state to offer different QHPs to individuals in different locations of the state if needed

Waiver Authority	Use for Waiver	Rationale for Waiver Request
	members to vary based on location.	based on QHP availability.
§ 1902(a)(4) Methods of Administration: Transportation	To the extent necessary, to enable Iowa not to assure non-emergency transportation to and from providers for the Marketplace Choice Plan.	This waiver authority will allow Iowa to align the benefits offered to QHP members who are not Medicaid beneficiaries. Legislation specifies benefits and does not include non-emergency transportation.
§ 1902(a)(4) Early Periodic Screening, Diagnoses, and Testing (EPSDT)	To exempt Iowa from the requirement to offer EPSDT services to 19 and 20 year olds and allow a standard set of benefits for all Marketplace Choice Plan members.	This waiver authority will allow Iowa to align the benefits offered to QHP members who are not Medicaid beneficiaries. Legislation specifies benefits and does not include non-emergency transportation.
§ 1902(a)(10)(A) FQHC/RHC Access	To enable Iowa not to cover all federally qualified health centers (FQHC) and rural health centers (RHC) when the Marketplace QHPs can demonstrate that Marketplace Choice Plan members will be adequately served through other providers.	For the initial demonstration year one of the two QHPs offered statewide includes all FQHCs and one does not. QHP networks may change in future years. This waiver authority will allow Iowa to provide premium assistance to Marketplace Choice Plan members enrolled in a Marketplace QHP that has fewer than all Iowa FQHCs in its network.
§ 1902(a)(10)(A) Family Planning Providers	To enable Iowa not to cover all family planning providers when the Marketplace QHPs can demonstrate that Marketplace Choice Plan members will be adequately served through other providers.	For the initial demonstration year the two QHPs offered statewide cover most, but not all of the family planning providers. QHP networks may change in future years. This waiver authority will allow Iowa to provide premium assistance to Marketplace Choice Plan members enrolled in a Marketplace QHP that has fewer than all Iowa family planning providers in its network.
§ 1902(a)(10)(B) Amount, Duration, and Scope of Services	To allow Iowa to offer a benefit package to Marketplace Choice Plan members that differs from the Medicaid State Plan	This waiver authority will allow Iowa to align the benefits offered to QHP members who are not Medicaid beneficiaries.

Waiver Authority	Use for Waiver	Rationale for Waiver Request
	services.	
§ 1902(a)(14) Cost Sharing Requirements	To allow Iowa to apply the federal 5 percent out-of-pocket maximum to be calculated on an annual basis instead of a quarterly basis.	This waiver authority will allow Iowa to align with how carriers will apply the annual cost-sharing limit for commercial coverage in the individual market.
§ 1902(a)(14) Cost Sharing Requirements	To allow Iowa to charge a $10 copayment for non-emergency use of the emergency department.	This waiver authority will allow Iowa to meet the requirements of the Iowa Health and Wellness Plan legislation.
§ 1902(a)(15) & 1902(bb) FQHC/RHC Reimbursement	To permit Iowa to limit reimbursement for federally qualified health centers (FQHC) and rural health centers (RHC) to the amount the FQHC/RHC negotiated with the QHP carrier, rather than the amount established under the prospective payment system.	This waiver authority will allow Iowa to limit its financial exposure and align reimbursement to FQHCs/RHCs for Marketplace Choice Plan members with QHPs' contracted rates.
§ 1902(a)(17) Comparability	To permit Iowa to provide coverage through different delivery systems for different populations of Medicaid beneficiaries. Specifically, to permit Iowa to provide coverage for Marketplace Choice Plan eligible Medicaid beneficiaries through QHPs offered in the individual market.	This waiver authority will allow Iowa to test using premium assistance to provide coverage for QHPs offered in the individual market through the Marketplace or a subset of Medicaid beneficiaries.
§ 1902(a)(23) Freedom of Choice	To allow Iowa to make premium assistance for Marketplace QHPs mandatory for Marketplace Choice Plan members, limit members' choice of providers to those providers participating in the Marketplace QHPs, and restrict the delivery system to the choice of two Marketplace QHPs.	This waiver authority will allow Iowa to require that Marketplace Choice Plan members receive coverage through the demonstration and not through the Medicaid State Plan. This waiver authority will also allow Iowa to align the network available to Marketplace Choice Plan members with the network offered to QHP members who are not Medicaid beneficiaries.
§ 1902(a)(23) Freedom of	To allow Iowa to make eligible	This waiver authority is

Waiver Authority	Use for Waiver	Rationale for Waiver Request
Choice	individuals, who have access to cost-effective ESI coverage, enroll in the cost-effective ESI coverage and receive premium assistance through the HIPP Program and to limit such individuals' choice of providers to those providers participating in the cost-effective ESI health plans.	consistent with Iowa's current HIPP Program policy around cost-effective ESI. It will allow the state to test ESI as a coverage tool for this population and will align the program with Iowa's goals of maximizing commercial market coverage.
§ 1902(a)(34) Retroactive Eligibility	To allow Iowa to not offer Marketplace Choice Plan members retroactive eligibility.	This waiver authority will allow Iowa to align eligibility dates for Marketplace Choice Plan members with standards in the commercial market. The enabling legislation specifies enrollment as of the 1st of the month following eligibility and does not allow for retroactivity.
§ 1902(a)(54) Drug Formulary	To permit Iowa to limit Marketplace Choice Plan members to receiving coverage for drugs on the selected Marketplace QHP's drug formulary.	This waiver authority will allow Iowa to align the prescription drug benefit for Marketplace Choice Plan members with the prescription drug benefit offered to QHP members who are not Medicaid beneficiaries.
§ 1902(a)(54) Emergency Dispensing and Prior Authorization	To permit Iowa to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.	For the initial demonstration year one of the two statewide QHPs meet this requirement, and the other meets the prior authorization requirement but has no standards around emergency dispensing. QHP policy may change over time. This waiver authority will allow Iowa to align prior authorization standards for Marketplace Choice Plan members with standards in the commercial market while effectively meeting the requirement.

Submission of Medicaid State Plan Amendments (SPAs)

CMS Request: List the Medicaid State Plan amendments (SPAs) that will be submitted and the timing for submission, including those related to eligibility, benefit, cost sharing, and delivery systems.

Iowa will submit the necessary SPAs in accordance with the required timeframes.

Payment of Premiums

CMS Request: Describe the process the state will use to operationalize the payment of premiums for participating individuals.

Iowa will reimburse the Marketplace Choice Plan QHPs for the full premium directly on a monthly basis. After the first year of enrollment, members will be required to pay a monthly financial contribution towards their premium in accordance with the Cost Sharing section. Marketplace Choice Plan members will be exempt from paying a monthly required contribution for the first year of enrollment. After the first year of enrollment, the required financial contributions will be waived if the participant has met all health improvement requirements in the preceding year. Members, who do not complete health improvement behaviors to waive their financial contribution, will pay their portion of the required financial contribution directly to Iowa, and Iowa will continue to pay the full premium to the Marketplace QHP. Iowa will not contract directly with the Marketplace Choice Plan QHPs but will, instead, implement a written agreement outlining expectations regarding payment of premiums, enrollment verification, referrals of medically frail individuals, and other related issues.

For those individuals, who are enrolled in a cost-effective ESI health plan, Iowa will provide premium assistance for the ESI health plan through the HIPP Program. The monthly premium is deducted from the individual's paycheck, and Iowa then directly reimburses the individual.

Cost Sharing

CMS Request: Describe the collection of cost sharing including any grace periods.

Participant financial contribution under the Marketplace Choice Plan has unique and innovative features designed to encourage utilization of preventive care and overall health promotion and disease prevention through an incentive based program. During their first year of enrollment, all Marketplace Choice Plan members are exempt from financial contributions. Starting in their second year of enrollment, members will be subject to a monthly financial contribution unless they have completed certain health improvement behaviors in their initial year of enrollment. Participant financial contribution amounts are indexed to be approximately three percent of income for a two-person household where both members are enrolled in the Marketplace Choice Plan. This level of contribution ensures that members can make their monthly contribution amounts without reaching the federal 5 percent of the out-of-pocket maximum limit, even if they make copayments for non-emergency use of an emergency room. Financial contribution amounts are detailed in Table 5 below. Although eligible individuals, who have cost-effective ESI coverage, will not be enrolled in the Marketplace Choice Plan and, instead, will receive premium assistance for their ESI coverage through the HIPP Program, such

individuals will be subject to the same cost sharing provisions as set forth in this section in future years of the demonstration.

Table 5: Required Contributions

Percent of the FPL	Median Income Single		Individual contribution	
	Monthly	Annual	Monthly	Annual
101 percent of the -133 percent of the [6]	$1,139	$13,673	$20	$240

The Marketplace Choice Plan creates an incentive program that provides members with the opportunity to have their monthly financial contributions waived. Iowa will establish a list of key health activities in which a participant may participate during their enrollment period, such as health risk assessments, preventive services, and annual physicals, or other activities related to health promotion and disease prevention. If the participant completes these activities, they are exempt from paying monthly contributions in the following 12-month enrollment period. The incentivized health behaviors or activities for the first year of the demonstration will be for members to complete a health risk assessment and obtain a wellness examination from their primary care provider. Iowa will evaluate and further refine the health behavior requirements for the second year and beyond of the demonstration.

Members, who choose not to complete the required health improvement behaviors in order to receive the waiver, will be required to begin submitting their monthly financial contribution during the subsequent 12-month enrollment period. Members will have the opportunity to request a hardship waiver if they cannot afford to pay their monthly contribution. In addition, the Marketplace Choice Plan provides these members with a 60-day grace period to submit their financial contributions if they do not submit their financial contributions on time. Once a participant is late in submitting their required financial contribution payment, Iowa will initiate outreach to ensure the participant is aware that payment has not been received and of the consequences of continued non-payment. Members who do not pay outstanding financial contributions in full by the end of the 60-day grace period will be terminated from the Marketplace Choice Plan. Individuals who have been terminated from the Marketplace Choice Plan for non-payment of required financial contributions must then reapply for the Marketplace Choice Plan and be determined eligible to receive coverage.

The Marketplace Choice Plan will only include a $10 copayment for non-emergency use of the emergency department. The definition for non-emergency use of the emergency department will

[6] Upper income limit at 133 percent of the FPL accounts for 5 percent of the disregard to 138 percent of the FPL.

be consistent with the definition used for the Iowa Children's Health Insurance Program (hawk-i) which requires that the condition be perceived as life threatening or causing additional harm without immediate medical care. Because the Marketplace QHPs to which the members will have access may not be able to change their plan filings for this year to include the $10 copayment, the Marketplace Choice Plan members' $10 copayment will not be collected during the first year of the demonstration. Iowa will work with the Marketplace QHPs to add the $10 copayment to the Marketplace QHPs available to the Marketplace Choice Plan members in the second year of the demonstration. Iowa will also investigate ways to implement the $10 copayment for non-emergency use of the emergency department retrospectively through review of claims data.

Participant financial contributions are indexed to amounts that equate to three percent of the income for a household of two enrolled in the Marketplace Choice Plan. Beyond these financial contributions, the only payments a participant will be responsible for is the aforementioned $10 copayment for non-emergency use of the emergency department. Table 6 below displays the number of non-emergency visits to the emergency department that an individual would have to make to meet the federal 5 percent of income cost sharing limit.

Table 6: Cost Sharing and 5 percent of Income Limit

Percent of the FPL	Median Income	5 percent of Median Income Limit	Annual Contribution	ED Copayments to Reach 5 percent of income[7]
101 percent of the -133 percent of the [8]	$13,673	$684	$240	44

Including these copayments, all cost sharing will be subject to the 5 percent out-of-pocket maximum limit. When members approach their 5 percent limit, payment of copayments for non-emergency use of the emergency department will take precedence over payment of monthly contributions. This 1115 waiver application requests a waiver to base the 5 percent out-of-pocket maximum limit on annual income in place of monthly or quarterly income. Members will be permitted to request a reassessment of their 5 percent out-of-pocket maximum if they meet certain qualifying conditions including a change in income or adding or losing a dependent. All household cost sharing amounts paid to Iowa Medicaid will be included in determining if the participant has met their 5 percent out-of-pocket maximum. This will include consideration for any other cost sharing paid by the member's household for Iowa Medicaid programs and services.

[7] This column shows the number of emergency department visits required to reach the 5 percent of the of income out-of-pocket maximum contribution level' it accounts for the required monthly contributions and is based on income for a single individual.

[8] Upper income limit at 133 percent of FPL accounts for 5 percent of disregard to 138 percent of FPL.

As compared to the traditional Medicaid program, the Marketplace Choice Plan offers members the predictability and certainty that the only financial contributions they are responsible for are copayments for non-emergency visits to the emergency department and their monthly financial contribution, which can be waived through the completion of health improvement behaviors or potentially waived via a hardship waiver request.

CMS Request: Describe the project that will be used to wrap any cost sharing obligations.

Marketplace Choice Plan members will be offered, at a minimum, two 100 percent of the actuarial value health plans offered on the Marketplace to the American Indian and Alaska Native populations. Therefore, members will have no cost sharing copayment obligations outside of non-emergency use of the emergency department.

Evaluation

CMS Request: Describe the evaluation hypotheses that the State will be tested during the demonstration including components in the alternative cost-effectiveness test and the plan by which the state will use to test them.

The Marketplace Choice Plan implements unique features including leveraging qualified health plans for enrollment of a portion of the Medicaid Expansion Population, cost sharing tied to preventive care seeking behavior, a commercial market benefit design, and policies to discourage non-emergency use of the emergency department. The Marketplace Choice Plan will test if conducting Medicaid Expansions through Marketplace QHPs results in improved access to care for both Marketplace Choice and traditional Medicaid members, if a commercial market benefit package that excludes Medicaid wrap services is appropriate for the population, if the innovative cost sharing structure is effective at increasing preventive care visits and decreasing non-emergency use of the emergency room, and if covering the Marketplace Choice members through the Iowa Marketplace results in system wide benefits for all Iowa citizens that impact program cost effectiveness. This draft evaluation outline offers an overview of the test purpose, hypothesis, methodology, comparison groups, potential metrics and potential data sources. Upon waiver approval a more detailed evaluation plan will be developed.

Table #: Marketplace Choice Initial Hypotheses and Evaluation Parameters

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
Access						
1	To test that mandatory enrollment in a QHP premium assistance option increases provider access for premium assistance members.	Marketplace Choice Plan members will have greater access to health care providers than they would have had in traditional fee-for-service Medicaid coverage.	Compare extent and comprehensiveness of traditional Medicaid and Marketplace Choice Provider Networks for primary and specialty care by geography and region. Compare the percent of the Marketplace Choice Plan members who reported how often they get care quickly in the Marketplace Choice Plan to traditional Medicaid. Compare quality and outcome metrics	Traditional Medicaid Members	Comparative map of network comprehensiveness Percent of the of members who report having a primary care physician Percent of the of members who report they get care quickly when needed Outcome and Quality Metrics including: asthma hospital readmissions, diabetes related amputation, provision of appropriate care regimens, etc.	QHP provider network data Medicaid State Plan provider network data Medical Expenditure Panel Survey from AHRQ (MEPS) NCQA HEDIS CAHPS QHP enrollee satisfaction data Marketplace Choice Survey
2	To test the impact of the provision of dental services through a commercial market option.	Members in the Marketplace Choice Plan will experience greater access to dental providers than members in traditional Medicaid.	Compare access to dental services	Traditional Medicaid	Percent of the of members receiving preventive dental care Percent of the	Claims data Marketplace Choice survey

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
					members who report they get care quickly when needed Dental outcome metrics as available	
3	To test that Marketplace Choice Members have sufficient access to FQHCs and Family Planning Providers.	Members in the Marketplace Choice Plan will have comparable access and utilization of FQHCs and Family Planning providers as members of traditional Medicaid and Iowa Wellness Plan members.	Compare access to FQHC and Family Planning Providers. Compare quality/outcome for Marketplace Choice and Traditional Medicaid.	Traditional Medicaid Iowa Wellness Plan	Percent of the members reporting difficulty accessing FQHC and Family Planning Provider Rate of members in comparison groups accessing these providers. Quality metrics such as adherence to treatment, asthma hospital readmissions, etc.	Claims data Marketplace Choice survey
4	To test the impact of the waiver for the provision of non-emergency transportation services on the Marketplace Choice Plan population.	The waiver of non-emergency transportation services does not pose a barrier to access of care for Marketplace Choice Plan members.	Conduct a survey of Marketplace Choice Plan members to determine if members experience barriers to access due to elimination of non-emergency transportation services. Review member's ability to access care in comparison with traditional Medicaid members. Compare member's use of emergency transportation,	Traditional Medicaid population	Enrollee report of access issues through enrollee survey. Access to care metrics including use of emergency transportation, adherence to appointments, number of	Marketplace Choice Plan Survey Claims data

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
			adherence to appointments, preventive care visits, and adherence to appropriate care regimens to traditional Medicaid members.		preventive care visits, and adherence to appropriate care regimens.	
5	To test the impact on access to care of mandatory enrollment for individuals with cost-effective ESI.	Members with cost-effective ESI that are mandatorily enrolled in that coverage have comparable access to care as individuals enrolled in QHPs through the Marketplace Choice Plan.	Conduct a survey of Marketplace Choice members and those enrolled in ESI through the Marketplace Choice Plan option and compare access to care.	Marketplace Choice Plan Members	Percent of the of members who report having a primary care physician Percent of the of members who report they get care quickly when needed	Marketplace Choice Survey
6	To test the impact of the waiver of EPSDT services, specifically vision services, for qualifying individuals.	The waiver of EPSDT does not pose a barrier to access of care for Marketplace Choice members.	Conduct a survey of EPSDT eligible Marketplace Choice Plan members to determine if members experience barriers to access due to elimination of EPSDT services. Screening services will be covered under ABP preventive benefits and dental services will be covered through coordination with a commercial dental plan. Hearing aids are covered by the commercial market EHB. Vision services will be the main eliminated benefit.	Traditional Medicaid population	Percent of the qualifying members (19 & 20) that report unmet need or inability to pay for vision services.	Marketplace Choice Survey
7	To test the impact of providing Marketplace Choice Plan members with the QHP pharmacy benefit.	QHP pharmacy benefits are adequate for marketplace choice members.	Conduct a survey of Marketplace Choice Plan members to determine if they experienced unmet pharmacy needs due to differences between the QHP formulary and the Medicaid State Plan formulary.	Traditional Medicaid population	Percent of the members reporting an unmet need for pharmaceuticals Enrollee adherence	Marketplace Choice Enrollee Survey Claims data

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
			Compare pharmaceutical use of Marketplace Choice Plan and traditional Medicaid members to identify differences in pharmaceutical adherence or prescription regimens.		to pharmaceutical regimens Appropriateness of drug regimens by condition	
Cost Sharing						
8	To test the impact of the $20 financial contribution on members. To test if the contribution is affordable for members, how members experience the disenrollment process for non-payment, and if the contribution impacts care seeking behavior.	The monthly $20 financial contribution requirement does not pose an Access to care barrier for Marketplace Choice members.	Compare the experience of members that are subject to the $20 monthly premium payment to the experience of members that complete preventive services in the prior year and are not subject to this payment. • Survey members that are subject to the required financial contribution to determine if the amount of financial contribution is reasonable for members. Analyze experience of Marketplace Choice Plan members that do not pay within the 60-day grace period and are disenrolled. • What percent of the members reenroll? • Survey disenrolled members to determine reason for disenrollment. Analyze the percent of Marketplace Choice Plan members who are subject to the financial contribution	Marketplace Choice Plan members not subject to $20 payment. Marketplace Choice Plan Members not disenrolled. Marketplace Choice Members that request a hardship exemption. Traditional Medicaid	Enrollee knowledge of the program Enrollee report on if the financial contribution is 'too low, just right, too high' Enrollee report on reason for disenrollment Quality of care metrics for members subject to and not subject to required contributions including: asthma hospital readmissions, diabetes related amputation, provision of appropriate care regimens, etc.	Marketplace Choice Enrollee Survey Enrollment data

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
			in year 2 that receive preventive services in that year. • Survey members to determine if being subject to required contribution impacted their decision making around seeking preventive care Analyze the Marketplace Choice Plan members who are subject to the $20 contribution but request a hardship waiver. • What are the distinguishing characteristics of members that do or do not request hardship waivers? • Are members aware of the hardship waivers? • How many members request hardship waivers? Examine access and quality of care for members subject to and not subject to required contributions			
9	To test the impact of the $10 copayment on the non-emergency use of the emergency department	The $10 copayment for non-emergency use of the emergency department is effective in impacting the number of non-emergency visits to the emergency department.	Survey marketplace choice members on non-emergency use of the emergency department and determine the impact of the $10 required copayment. Compare impact of $10 copayment for non-emergency use of the emergency department, to other programs with lesser copayment	Traditional Medicaid Other State's Medicaid Populations	Member response to whether copayment impacted decision making on emergency department use Member response on if copayment	Marketplace Choice Plan Member Survey Hospital emergency department use data

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
			amounts for non-emergency use of the emergency department in Iowa and other states.		was 'too low, just right, too high'	
Utilization						
10	To test if the $20 financial contribution that is implemented in year 2 if members do not receive services in year 1 is effective at encouraging enrollee use of preventive care.	Marketplace Choice Plan members will use preventive care services at a greater rate compared to the traditional Medicaid members, Medicaid beneficiaries in non-premium assistance expansions nationally, and will have a comparable or greater rate or preventive service utilization as commercial market members and Iowa Wellness Plan Members.	Compare the percent of Marketplace Choice Plan members with a preventive care visit in the last year with the traditional Medicaid population, Medicaid expansion populations in non-premium assistance states, and the commercial market.	Traditional Medicaid Population Commercial Market Population Iowa Wellness Plan Members Medicaid Expansion populations in other states	Rate of preventive care utilization	CDC- Behavioral Risk Factor Surveillance System Claims Data *Potential: Other State Expansion Data on Preventive Care Utilization*
11	To test if the cost-sharing policy related to non-emergency use of the emergency department is effective at reducing non-emergency department visits.	Marketplace Choice Plan members will have decreased utilization of emergency department services as compared to Medicaid beneficiaries in traditional Medicaid and will have comparable non-emergency use of the emergency department as the Iowa Wellness Plan and commercial populations.	Compare the percent of members with hospital emergency department as usual source of care to traditional Medicaid. Compare non-emergent ER use in Marketplace Choice and FFS.	Traditional Medicaid Iowa Wellness Plan Commercial Market populations	Percent of the Marketplace Choice Plan Members that report the emergency department as usual source of care PMPM non-emergent emergency department visits	Claims Data CAHPS NCQA HEDIS MEPS

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
Churn						
12	To test if enrollment in a QHP for the population between 100 percent and 133 percent of the FPL results in increased provider continuity for members that churn.	Members will maintain continuous access to the same QHPs and/or providers at higher rates than beneficiaries under a traditional Medicaid and Iowa Wellness Plan members that churn to the Marketplace Choice Plan.	Compare continuity of providers during churn events for Marketplace Choice Plan members and traditional Medicaid members.	Traditional Medicaid Iowa Wellness Plan members	Percent of the churning members reporting a change in usual provider	Marketplace Choice Plan Survey Claims Data
Cost- Effectiveness						
13	To test that the Marketplace Choice Plan is comparable in overall cost to a fee-for-service Medicaid expansion.	Assuming adjustments in the fee-for-service rate schedule to account for increased reimbursement that brings comparable provider access, the Marketplace Choice Plan demonstration has an average PMPM, including administrative costs, comparable to what it would cost to cover these individuals in a Medicaid fee-for-service expansion.	Analyze data on individual utilization in current Iowa Medicaid programs including dependent persons and Iowa Care. Analyze data on access issues for non-premium assistance Medicaid expansions that do not increase reimbursement rates. • Impact on access for traditional Medicaid members? • Impact on access for expansion members.	Iowa Care Dependent Persons Other State Data	PMPM Cost Projected increase in access based on increased reimbursement rates	Claims Data
14	To test that the Marketplace Choice Plan promotes increased market competition	The provision of premium assistance for Marketplace QHPs and bringing more Medicaid lives to the Iowa Marketplace will increase market stability and increase the participating QHPs and providers in the private market resulting in lower costs for all Iowans.	Determine size of individual market with and without Marketplace Choice Plan members. Analyze impact of including Marketplace Choice Plan population in the Iowa Marketplace. Analyze impact on insurer election to participate in the Marketplace		Percent of increase in Marketplace population due to Marketplace Choice Plan. Percent of increase in plans offered in the Marketplace over time.	IME enrollment data Individual Market enrollment data

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
			due to the Marketplace Choice Plan.			
15	To test the impact of the Marketplace Choice plan on reducing uncompensated and undercompensated care and provider cost shifting.	The Marketplace Choice Plan reduces the amount of uncompensated care, undercompensated care, and provider cost shifting.	Analysis of DSH payments Monitor and analyze change in commercial market premium rates in relation to change in uncompensated and under compensated care. Compare age adjusted rate trends for non-premium assistance expansion states to the Iowa Marketplace. Address: Does the increased provider rate provided by QHPs decrease undercompensated care and cost-shifting and level out cost for the entire Iowa Marketplace Population.	IowaCare Population Non-premium Assistance State Marketplace Rates	Change over time in percent of uncompensated care Change over time in percent of undercompensated care Change overtime in cost-shifting evaluated by age and health status adjusted commercial market rates.	DSH data Premium rate data over time IowaCare population utilization Hospital Uncompensated Care Report
16	To test if increased use of preventive care promoted in the Marketplace Choice Plan results in better outcomes and lower costs.	Increase in use of preventive care due to incentives embedded in the Marketplace Choice Plan promotes improved health outcomes and lower costs.	Analysis of claims data over time that compares indicators of successful chronic disease management among the target population, for example: fewer diabetes-related amputations, fewer hospital admissions for conditions like asthma, etc.	Traditional Medicaid	Diabetes related amputations Asthma Hospital Readmissions	Claims data
17	To test if decreased use of the emergency department as a source of usual care results in increased outcomes for members and decreased costs.	Decreases in non-emergency department use yield cost-savings and increases cost-effectiveness.	Compare non-emergency department use in the traditional Medicaid population with the Marketplace Choice Plan and project costs savings from reduction in non-emergency use of the emergency department.	Traditional Medicaid	Rate of emergency department use Percent of individuals that report emergency department as usual source of care	Claims data

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
Quality						
18	To test if the Marketplace Choice Plan results in increased quality for members.	The Marketplace Choice Plan increases overall quality of care for members.	The Marketplace Choice Plan QHPs will be asked to provide data on the same State Innovation Models quality metrics implemented in the Iowa Wellness Plan. The SIM model is a statewide multi-payor initiative that promotes the development of Accountable Care Organizations. Quality metrics will be implemented in a phased approach and may include attributed participant experience, primary and secondary prevention, tertiary prevention, population health status, continuity of care, chronic and follow-up care, and efficiency.	Traditional Medicaid	SIM Quality Metrics to include: Attributed participant experience Primary and secondary prevention Tertiary prevention Population health status Continuity of care Chronic and follow-up care	Quality metric data reported from QHPs CAHPS NCQA HEDIS QHP Enrollee Satisfaction Survey

Budget Neutrality

CMS Request: Provide projected expenditures and projected enrollment, including an estimate of the expected increase or decrease in annual enrollment and in annual expenditures over the 3 year demonstration period.

Please see the attached documents prepared by Milliman, Inc. describing financing and budget neutrality for the Marketplace Choice Plan.

CMS Request: Describe the process used to determine the total cost of the QHP and the Medicaid wrap. Please provide a per member/per month cost for each of these figures.

Medicaid wrap benefits are not necessary under the Marketplace Choice Plan. The only service not provided through the available Marketplace QHPs will be dental services, and those services will be provided through a commercial market plan.

Public Notice & Transparency

CMS Request: Describe the process used to meet section 1115 transparency regulatory requirements.

The public comment period initiates July 15, 2013. Please see the public notices attached as Appendix 1.

Summary of Public Comment

The majority of the comments were generally supportive of the consensus reached to create two Iowa waiver proposals and expand Medicaid coverage. There was one comment that expressed discomfort with the expansion in general. Four comments expressed that while the waiver proposals were preferable to no action, a straightforward Medicaid expansion as outlined by the federal government would have been simpler, more inclusive, less confusing, and less administratively complicated. One comment suggested that the administrative burden of managing essentially three different Medicaid programs would be more expensive for the State as well, and that the private health insurance plans leveraged in the Marketplace Choice Plan are focused on profit-making and are a poor choice for this population. One comment urged strong oversight and monitoring of the Qualified Health Plans to hold them accountable for patient service and proper procedures, including an appeals process. One comment noted that using Medicaid to pay private insurance premiums under the Marketplace Choice Plan may be more expensive for taxpayers. Other concerns and suggestions fell into four general categories: 1) Services that are not covered in the waiver proposals or require referrals and lack of retroactive eligibility; 2) The waiver proposal that beneficiaries pay premiums if they do not complete certain preventative services activities in the first year and annually thereafter; 3) The need for extensive consumer assistance and public education; 4) Certain definitions, language, and procedures that should be modified or further developed before the waivers are implemented.

Services Not Covered and Retroactive Eligibility

The most common concern cited was a lack of coverage for non-emergency medical transportation in the waiver proposals. Thirteen comments urged that non-emergency medical transportation should be a covered benefit, stating that failure to cover it would pose a significant barrier for this population to keep medical appointments, adhere to treatment regimens, and access the required preventative services to avoid paying premiums. Eight comments urged that EPSDT services also be covered, and that doing so would help children with disabilities avoid nursing home care and avoid treatment gaps. Two comments expressed concern for the waiver's lack of coverage of hearing and vision services. Two comments addressed the prescription drug formulary for the Qualified Health Plans available through the Marketplace plan: one expressed concern that Multiple Sclerosis drugs would not be covered and requested wraparound coverage for them, and the other asked that the formulary be as comprehensive as that of the State Employee plan. One comment asked that the waivers included Medication Therapy Management as a covered benefit, citing evidence that improved medication adherence leads to better health outcomes.

Ten comments were received advocating the elimination of the provision in the waivers that require a physician referral for chiropractic care. These comments cited the cost-effectiveness of chiropractic services and its ability to mitigate many different health problems, and stated that in many communities, chiropractors were the first and only point of entry to the healthcare system and patients would forgo needed care if they could not see one directly. The State received five comments advocating for coverage of Medical Nutrition Therapy for all patients, not just diabetic patients, citing research in its effectiveness in preventing and managing many types of chronic disease, and that the service should be provided by dieticians. One comment expressed concern over the reduction of habilitation and skilled nursing care benefits from 120 days to 90 days, stating that additional time can be critical to patients' recovery. One comment expressed concern over needing a referral to see a mental healthcare provider, as members that are not regularly in contact with their primary care providers would be excluded from mental health services. One comment stated that the plans should include full mental health parity.

Nine comments were received advocating that the waivers allow retroactive enrollment and billing the waiver plans. Comments stated that failing to do so would place a significant financial burden on hospitals and particularly on safety-net providers and reduce their ability to serve beneficiaries. Additionally, it would leave a population with very few resources vulnerable to extreme financial strain and liability.

Premium Payments and Preventative Requirements to Avoid Them

The State received thirteen comments on the waiver application's plans to charge premiums to beneficiaries in both plans after the first year if they do not complete certain required preventative activities. Nine of these comments suggested elimination or significant reduction of premium payments. These comments discussed the burden that even paying small premium

would place on this population, and suggested it would cause disenrollment. They also mentioned that people who are not accustomed to having access to healthcare would find it difficult to comply with the requirements to avoid paying premiums, and that some beneficiaries would not have the resources, transportation, or flexibility in their work schedules to comply. They noted that preventative care requirements should be considered in the context of barriers faced by low-income families. Some of the comments mentioned that requiring providers to report details on whether the beneficiaries had completed required key activities would impose a significant administrative and documentation burden, cutting into the time they have to provide care, as well as violate their confidentiality obligations to patients. One comment urged the State to consider whether the capacity exists to engage in this tracking and reporting. Additionally, five comments urged that the IME work closely with stakeholders to ensure that required preventative activities are achievable, realistic for the population, and evidence-based.

Consumer Assistance and Public Education

Several organizations/individuals mentioned that the waivers ask little-informed, vulnerable populations to make complex healthcare choices and decisions and stated that implementing multiple consumer assistance, outreach, and education strategies would be vital to ensure that people understand their options. Three comments noted concerns that having three different types of Medicaid plans would be particularly confusing (and administratively challenging) and one noted the importance of culturally and linguistically appropriate outreach efforts. Two comments addressed the need for a process to transition from Iowa Care so beneficiaries would not fall through the cracks.

One comment said that customers needed to have access to unbiased information about what the QHP's offer and that support services from the insurance industry are not unbiased. There were also several comments on the importance of ensuring a process to help people who are unaccustomed to having coverage learn the basics of how to use the healthcare system and understand the different features between the Qualified Health Plans in the Marketplace.

Definitions, Language, and Procedures to be Modified/Developed

One comment noted that the waiver should stipulate that ACO's use an outcomes-based method of reimbursement and one suggested that ACO's should be measured on population-level health outcome measure. Two comments requested that the language in the waiver should be changed such that Advanced Practiced Registered Nurses and D.O.'s could serve as the head of patient-centered medical homes and included as part of ACO's. One comment suggested that the definition of "medically frail" should be broadened to include more groups with complex needs for medical care and management. Two comments noted the need for a definition, and one proposed that a screening questionnaire be developed to help determine whether someone is "medically frail". One comment questioned the use of the term "medically frail", stating that it is insulting to people living with disabilities.

Two comments noted that “key preventative activities” that must be fulfilled in order to avoid premium payments have not been defined, and should be either eliminated or made simple and achievable. One comment noted that there is no definition for non-emergency use of the emergency room, and asked if there would be a definition and if it would be made available to beneficiaries.

Response to Comments

Iowa appreciates all commenters that took the time to comment either during a public hearing or to submit comments on the Iowa Wellness Plan and/or the Marketplace Choice Plan. Based on comment received the following changes and modifications have been made to the waivers.

- The final draft includes a hardship waiver for the payment of premiums.
    - Comments were received indicating concern for the provisions requiring payment of premiums if preventive health services are not obtained. Because the enabling legislation for the Marketplace Choice Plan and the Iowa Wellness plan lays out the provisions for premiums, these payments remain in the final waiver proposal. However, to address concerns that imposition of premiums could lead to disenrollment and cause financial hardship for this vulnerable population, and that obtaining the required services to avoid the premiums could be a challenge for some, the final version of the Iowa Wellness Plan and the Marketplace Choice Plan include a hardship waiver for individuals that cannot afford their premiums.
- The final draft removes the language that indicated referral was required for chiropractic services.
    - Comments were received requesting that individuals covered by the Iowa Wellness Plan be able to access chiropractic services with the referral of a primary care physician. The final draft modifies the language around referral requirements for Chiropractic services to make clear that referrals are not required.

Some comments were received regarding the benefits not included in the Marketplace Choice Plan and the Iowa Wellness Plan including NEMT, EPSDT, and nutritional counseling. The benefits that are included in these plans are based on the appropriate alternative benefit plan. The enabling legislation for the Marketplace Choice Plan and the Iowa Wellness Plan made clear that the benefits offered to these populations were intended to be a commercial, not a Medicaid package. In the legislation, outside of this benefit package the provision of adult dental services is provided for, however, additional services outside of those present in the ABP are not detailed. This policy also assures consistent benefits across the Iowa Wellness Plan, the Marketplace Choice Plan, and QHP coverage through the Marketplace. Thus, no additional benefit modifications are being made to these demonstration proposals as a result of the comments received.

In addition, comments were received noting concerns about the waiver’s proposal not to allow retroactive eligibility. The enabling legislation speaks to enrollment as of the first of the month following the eligibility determination and does not include provisions for retroactivity. Thus, no changes were made to the proposals as a result of the comments. Additionally, not allowing

retroactive eligibility for the plans maintains consistency with the policies of other Marketplace plans.

Other comments urged that Iowa consult with stakeholders to determine appropriate preventive health services, and to ensure individuals, especially those transitioning form IowaCare, receive appropriate outreach and education. Iowa agrees with the importance of consulting with stakeholders in determining targeted preventive services and a stakeholder consultation process is already underway that will help to define these services. In addition, Iowa recognizes the importance of consumer outreach and education around both the Iowa Wellness Plan and the Marketplace Choice Plan and will work to ensure that individuals understand the features of their coverage and are aware of the incentives gained by completion of targeted preventive services.

Federal Medical Assistance Percentage

Implementation of the Marketplace Choice Plan is dependent on the increased federal medical assistance percentage (FMAP) for the new adult group under the ACA (as provided in 42 U.S.C. § 1396d(y)). If the methodology for calculating the FMAP for members in the Marketplace Choice Plan is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to Iowa in a manner inconsistent with 42 U.S.C. § 1396d(y), or if federal law or regulation affecting eligibility or benefits for the Marketplace Choice Plan is modified, the Iowa Department of Human Services shall implement an alternative plan for coverage of the affected population, subject to prior, statutory approval of the implementation. In addition, if the methodology for calculating the FMAP for the Marketplace Choice Plan members is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to Iowa below 90 percent but not below 85 percent the medical assistance program reimbursement rates for inpatient and outpatient hospital services shall be reduced by a like percentage in the succeeding fiscal year.

Appendix 1: Notice of Public Hearing

Iowa Department of Human Services

Abbreviated Notice of Public Hearing and Public Comment Period

Under 42 CFR Part 431 and the final rule under PART 431 in the February 27, 2012, issue of the Federal Register, 77 FR 11678-11700, notice is hereby given that**: (1) on July 29, 2013, at 2:00 pm, at River Place, Room 1, 2309 Euclid Ave., Des Moines, IA 50310; and (2) on July 30, 2013, at 11:30 am, at Iowa Western Community College, Looft Hall Auditorium, 2700 College Road, Council Bluffs, IA 51503;** the Iowa Department of Human Services (IDHS) will hold public hearings on the Iowa Wellness Plan 1115 waiver request and the Marketplace Choice Plan 1115 waiver request that will be submitted to the Centers for Medicare and Medicaid Services (CMS) to implement the Iowa Health and Wellness Plan for calendar years 2014 through 2018. This notice also serves to open the **30-day public comment period, which closes August 15, 2013, at 4:30 pm.**

In May 2013, the Iowa legislature passed Senate File 446 containing the Iowa Health and Wellness Plan, which will replace the IowaCare 1115 demonstration that is set to expire December 31, 2013. The Iowa Health and Wellness Plan calls for health care coverage for Iowans, who are 19 to 64 years of age with incomes not exceeding 133 percent of the federal poverty level (FPL) and who are not eligible for Medicare or comprehensive Medicaid under an existing Iowa Medicaid group. Iowa is seeking two 1115 waiver requests to implement the Iowa Health and Wellness Plan: 1) the Iowa Wellness Plan 1115 waiver request; and 2) the Marketplace Choice Plan 1115 waiver request.

The Iowa Wellness Plan offers health care coverage to individuals, who have incomes below or equivalent to 100 percent FPL, through the utilization of accountable care organizations (ACOs) and medical homes. The Marketplace Choice Plan offers health care coverage to individuals, who have incomes above 100 percent FPL but not exceeding 133 percent FPL, through the utilization of premium assistance for health insurance marketplace (Marketplace) health plans. Income eligibility for both the Iowa Wellness Plan and the Marketplace Choice Plan will be determined using the modified adjusted gross income (MAGI) methodology.

Enrollment in the Iowa Wellness Plan and the Marketplace Choice Plan will initiate during the implementation of the Affordable Care Act's (ACA) Marketplaces beginning October 1, 2013. Individuals may apply with the single streamlined application through the Iowa Medicaid Enterprise (IME) channels or through the Marketplaces. Over the five-year demonstration period (2014-2018) the Iowa Health and Wellness Plan is expected to cost approximately $3.1 billion in total state and federal funds.

Benefits for both the Iowa Wellness Plan and the Marketplace Choice Plan will include preventative care services, home health services, physician services, inpatient/outpatient hospital services, emergency transportation, prescription drugs, diagnostic services, durable medical equipment and medical supplies, rehabilitative services, home health services, and mental health and substance abuse services. Dental benefits will be covered through a commercial market dental plan instead of through the Medicaid Dental benefit.

Participant financial contribution under the Iowa Wellness Plan and the Marketplace Choice is designed to encourage utilization of preventative care services. During their first year of enrollment, participants are exempt from monthly financial contributions. Starting in their second year of enrollment, participants with incomes at or above 50 percent FPL will be subject to a monthly financial contribution or premium payment unless such financial contributions are waived based upon completion of certain required preventative activities in the prior year. In addition, both plans include an $10 co-payment for non-emergency use of the emergency room that applies to all participants regardless of income.

The full Public Notice and the proposed Iowa Wellness Plan 1115 waiver and Marketplace Choice Plan 1115 waiver documents are available for public review at the DHS County Offices. The documents may also be viewed beginning on July 15, 2013, at: http://www.ime.state.ia.us/Initiatives.html.

Written comments may be addressed to Maggie Reilly, Department of Human Services, Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, IA 50315. Comments may also be sent to the attention of: **DHS, Iowa Health and Wellness Plan** at DHSIMEHealthandWellnesPlan@dhs.state.ia.us **through August 15, 2013**. The public, by contacting Maggie Reilly at the above address, may review comments received.

Jennifer Vermeer
Medicaid Director
Iowa Medicaid Enterprise
Iowa Department of Human Services

Iowa Department of Human Services

Notice of Public Hearing and Public Comment Period

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Iowa is seeking two 1115 waiver requests to implement the Iowa Health and Wellness Plan: 1) the Iowa Wellness Plan 1115 waiver request; and 2) the Marketplace Choice Plan 1115 Demonstration waiver request. The Iowa Wellness Plan 1115 waiver request applies to Iowans ages 19 to 64 with income up to and including 100% FPL for those who are not medically frail and income up to and including 133% FPL for those who are medically frail. Enrollees of the Iowa Wellness plan will receive coverage through independent PCPs, PCPs associated with ACOs, or managed care plans, and medically frail individuals will be defaulted to enrollment in the State Plan but may opt-out to receive coverage through the Iowa Wellness Plan. The Marketplace Choice Plan 1115 waiver request addresses coverage for non-medically frail Iowans ages 19 to 64 with income 101% FPL to no more than 133%[9]

[9] With the 5% of FPL disregard, individuals with household income up to 138% FPL may be eligible.

FPL through the utilization of premium assistance for Marketplace QHPs. Iowa seeks this waiver authority under Section 1115 of the Social Security Act and will request approval of the two new demonstrations from CMS.

OBJECTIVES

The Iowa Department of Human Services (IDHS) developed the Iowa Wellness Plan 1115 waiver request and the Marketplace Choice Plan 1115 waiver request to implement the Iowa Health and Wellness Plan with the goals of creating an innovative approach to providing health care services to Iowa's low-income population and assuring cost-effective coverage opportunities for all Iowans.

Three objectives have driven the development of the Iowa Wellness Plan 1115 waiver request and the Marketplace Choice Plan 1115 waiver request: 1) ensuring that all Iowans have access to a health insurance coverage option in 2014 through the Iowa Wellness Plan or Marketplace Choice Plan demonstrations, other Medicaid programs, Medicare, or the Marketplace; 2) implementing a new delivery system and payment model to promote improved care management, care coordination, and health care quality, and 3) implementing a unique incentive plan to encourage development of cost-conscious consumer behavior in the consumption of health care services and to improve the use of preventive services and other healthy behaviors by waiving required contributions in subsequent enrollment periods for individuals that complete targeted preventive health services, health risk assessments, or other identified healthy behaviors.

BENEFICIARIES, ELIGIBILITY, & FINANCING

The Iowa Health and Wellness Plan is designed specifically for individuals who have income below 133% FPL, are 19 to 64 years of age, not currently eligible for comprehensive Medicaid under an existing Iowa Medicaid group, not eligible for Medicare, and do not have access to cost-effective ESI. Individuals, who are not medically frail and meet the aforementioned criteria and who have income up to and including 100% FPL and individuals who are medically frail meeting the same requirements with income up to and including 133% FPL, will be eligible for the Iowa Wellness Plan, which offers coverage through PCP gatekeepers, managed care plans, and the utilization of ACOs. Individuals, who meet the aforementioned criteria, who are not medically frail, and who have income 101% FPL to no more than 133% FPL, will be eligible for the Marketplace Choice Plan, which offers coverage through the utilization of premium assistance for Marketplace QHPs. Income eligibility for both the Iowa Wellness Plan and the Marketplace Choice Plan will be determined using the modified adjusted gross income (MAGI) methodology.

Maintaining the commitment to leverage the private insurance market, eligible individuals, who have access to cost effective ESI, will not be eligible for the Iowa Wellness Plan or the Marketplace Choice Plan. Instead, Iowa will provide premium assistance to these individuals through Iowa's Health Insurance Premium Payment (HIPP) program. In addition, eligible individuals, who meet the definition of medically frail status, will be defaulted to fee-for-service coverage under the Medicaid State Plan based upon the complexity of these individuals' medical management and needs; however, these medically frail individuals will have the opportunity to opt-out of this coverage and receive coverage through the Iowa Wellness Plan.

Eligibility for all other Medicaid categories will take precedence over enrollment in either the Iowa Wellness Plan or the Marketplace Choice Plan. Enrolled individuals who become eligible for another Medicaid eligibility category will be transferred. This change will be done with no disruption of medical assistance to the individual but is required to ensure that the Iowa Health and Wellness Plan is sustainable and can cover the maximum number of Iowans.

Enrollment in the Iowa Wellness Plan and the Marketplace Choice Plan will begin October 1, 2013. Individuals may apply with the single streamlined application through the IDHS channels or through the Marketplaces. Coordination between the IDHS and the Marketplaces will ensure that individuals who meet the eligibility requirements are enrolled in the Iowa Wellness Plan or the Marketplace Choice Plan.

The tables below provide estimated numbers of individuals eligible for the Iowa Wellness Plan and the Marketplace Choice Plan. Both plans are funded sufficiently to provide services to the population expected to enroll.

Iowa Wellness Plan 1115 Waiver (0-100% FPL) Estimated Enrollees by Year

	2014	2015	2016	2017	2018
Wellness Plan	58,923	75,288	76,417	77,563	78,726
Medically Frail (State Plan)	38,146	42,795	43,437	44,088	44,749
Total	**97,069**	**118,083**	**119,854**	**121,651**	**123,475**

Marketplace Choice Plan 1115 Waiver (101-133% FPL) Estimated Enrollees by Year

	2014	2015	2016	2017	2018
Marketplace Plan	21,788	31,673	32,148	32,630	33,119
Total	**21,788**	**31,673**	**32,148**	**32,630**	**33,119**

Over the five-year demonstration period (2014-2018) the Iowa Health and Wellness Plan is expected to cost approximately $5.6 billion in total state and federal funds. The table below provides the estimated total state and federal costs divided by year and plan.

Estimated Total State and Federal Program Cost 2014-2018 (in millions)

	2014	2015	2016	2017	2018	Total
Wellness Plan						
0-100% Wellness Plan	$262.8	$344.0	$357.6	$371.9	$386.6	$1,722.9
0-133% Medically Frail	$483.0	$555.1	$577.2	$600.2	$624.1	$2,839.6
Total	$745.8	$899.1	$934.8	$972.1	$1,010.7	$4,562.5
Marketplace Choice Plan						
101-133%	$137.4	$204.7	$212.8	$221.3	$230.1	$1,006.3
Total	$137.4	$204.7	$212.8	$221.3	$230.1	$1,006.3
Grand Total	$883.2	$1,103.8	$1,147.6	$1,193.4	$1,240.8	$5,568.8

BENEFITS

The Iowa Health and Wellness Plan will provide a comprehensive benefit package that ensures coverage for all of the Essential Health Benefits (EHB) as required by the Affordable Care Act (ACA).

Benefits for the Iowa Wellness Plan for eligible non-medically frail individuals with income up to and including 100% FPL without access to cost-effective ESI are indexed to the benefits offered through the State Employee plan. Medically frail individuals with incomes up to and including 133% FPL without access to cost-effective ESI will be defaulted to State Plan coverage but may opt into the coverage provided on the Iowa Wellness Plan. All medical benefits will be provided through the current Iowa Medicaid contracted provider network. Dental benefits similar to those provided on the State Plan will also be offered to this population.

The Marketplace Choice Plan for eligible individuals with income 101% FPL to no more than 133% FPL without access to cost-effective ESI will cover all required EHB services. Benefits covered on this plan will be at least equal to the State Employee plan benefits. Iowa will supplement the Marketplace QHPs with dental services.

Both plans are requesting a waiver of the requirements to offer non-emergency transportation services and Early Periodic Screening, Diagnoses, and Testing (EPSDT) services to individuals between the ages of 19 and 21 in order to standardize the benefit package for participants.

PROPOSED HEALTH CARE DELIVERY SYSTEM

The Iowa Health and Wellness Plan offers innovations and reform in the delivery of health care services through the leveraging care coordination models including PCP gatekeepers, managed care plans, ACOs, and the utilization of the private insurance market. The Iowa Wellness Plan will deliver services on a fee-for-service basis through any enrolled Iowa Medicaid provider to individuals enrolled through an independent PCP or ACO or capitated basis through a managed care plan's network. The goal of the PCP, ACO, and managed care plans is to ensure that participant care is coordinated to the greatest extent possible to help to create efficiencies and improve the quality of individual health care. PCPs will be compensated with a coordinated care fee for managing enrollee care. Managed care plans will receive per member per month capitation. ACOs will be subject to a global budgeted amount that is calculated based on the number and relative risk of their participants. The budget will be risk-adjusted and ACOs will be protected with stop/loss provisions for high cost medical events. ACOs that come in under their global budget are eligible to share in savings at year-end provided that they meet specified quality metrics that are on target with established goals. Initially, ACOs will be eligible for shared-savings without being responsible for losses. Over time, two-way risk sharing will be introduced and ACOs will be financially responsible for exceeding their global budget amount.

The Marketplace Choice Plan strengthens Iowa's health care delivery system. Iowa's leveraging of Marketplace QHPs for the purpose of providing health care coverage for low-income individuals not only increases access to much-needed care but also brings more people to the private market resulting in greater quality, efficiencies, and cost-savings for all Iowans. Marketplace Choice Plan participants, based upon their level of income, are the most likely population to experience eligibility churn where they move from Medicaid eligibility to eligibility for premium tax credits on the Marketplace. Provision of coverage for these individuals through the Marketplace will facilitate transition to subsidized Marketplace coverage. Marketplace Choice Plan participants will receive services through providers enrolled in their selected Marketplace QHP. Marketplace QHPs will cover services at least as comprehensive as the State Employee plan services. Marketplace Choice Plan participants will also be provided with access to dental benefits similar to those provided on the Medicaid State Plan.

Eligible individuals, who meet the definition of medically frail, will be enrolled by default into standard Medicaid State Plan benefits and have access to more robust services to manage complex mental health and medical conditions; however, these individuals may opt-out of the State Plan benefits and receive coverage through the

benefits provided to non-medically frail individuals on the Iowa Wellness Plan. Medically frail individuals that remain enrolled in Medicaid State Plan coverage will have access to any enrolled Medicaid provider.

COST SHARING REQUIREMENTS

Participant financial contribution and copayments under the Iowa Wellness Plan and the Marketplace Choice Plan have unique and innovative features designed to encourage utilization of preventive care and overall health promotion and disease prevention through an incentive-based program. During their first year of enrollment, Iowa Wellness Plan and Marketplace Choice Plan participants are exempt from monthly financial contributions. Starting in their second year of enrollment, participants with income at or above 50% FPL will be subject to a monthly financial contribution or premium payment unless such financial contributions are waived based upon completion of certain preventive activities in the prior year. Iowa will establish a list of key activities in which a participant may participate during their enrollment period, such as risk assessments, preventive services, annual physicals, or other activities related to health promotion and disease prevention. If the participant completes these activities, they are exempt from paying monthly contributions in the following year.

The Iowa Wellness Plan and the Marketplace Choice Plan will include a $10 copayment for non-emergency use of the emergency department for all participants. This copayment is waived in the initial demonstration year.

Participant monthly financial contribution amounts are set to be a maximum of 3% of income for a two-person household when both household members are enrolled in either the Iowa Wellness Plan or the Marketplace Choice Plan. This level of contribution should ensure that participants could make their monthly contribution amounts without reaching the federal 5% out-of-pocket maximum limit, even if they make copayments for non-emergency use of emergency room use services.

Although eligible individuals, who have cost-effective ESI coverage, will not be enrolled in the Iowa Wellness Plan or the Marketplace Choice Plan but will, instead, receive premium assistance for their ESI coverage through the Iowa HIPP program, such individuals will be subject to the same cost sharing provisions as the Iowa Wellness Plan and the Marketplace Choice Plan participants in future years of the demonstration.

HYPOTHESES & EVALUATION

The Iowa Wellness Plan demonstration will investigate the following research hypotheses.

1) The Iowa Wellness Plan is designed to offer coverage options for non-medically frail Iowans with income not exceeding 100% FPL and for medically frail Iowans with income not exceeding 133% FPL, who are ages 19 to 64, and are not otherwise eligible for Medicaid, Medicare, or subsidized Marketplace coverage. Combined with current Medicaid and Medicare coverage options, the Iowa Marketplace Choice Plan waiver submitted simultaneously with this request, and subsidized coverage through the Marketplace, this will ensure that all Iowans have access to a coverage option in 2014.
2) To promote improved care management, care coordination, and health care quality, the Iowa Wellness Plan pioneers a new delivery system and payment model that leverages different models depending on availability and incorporates ACOs, managed care, and PCP gatekeepers.
3) The Iowa Wellness Plan will implement a unique incentive plan to encourage development of cost-conscious consumer behavior in the consumption of health care services and to improve the use of preventive services and other healthy behaviors by waiving required contributions in subsequent enrollment periods for individuals who complete preventive health services, health risk assessments, or other identified services.

The Marketplace Choice Plan will investigate the following research hypotheses.

Access

- Hypotheses:
    - Marketplace Choice Plan participants will have greater access to health care providers than they would have had in traditional fee-for-service Medicaid coverage due to increased reimbursement for providers.
    - Marketplace Choice Plan participants will have similar access to health care providers as others who are insured through the private market.
    - Marketplace Choice Plan participants will obtain preventive care services.
    - Marketplace Choice Plan participants will have decreased utilization of emergency department services as compared to Medicaid beneficiaries in traditional fee-for-service coverage.
- Evaluation:
    - Compare Marketplace Choice Plan and traditional fee-for-service Medicaid primary care and specialty care health care providers.
    - Perform a survey of Marketplace Choice Plan participants related to timeliness of care, use of emergency department services, receipt of ambulatory or preventive care services, and other access issues.
    - Compare denied emergency department claims for Marketplace Choice Plan participants and Medicaid fee-for-service beneficiaries.

Churn

- Hypotheses:
    - The use of the Marketplace for individuals who are at higher incomes will result in lower Medicaid administrative costs due to the reduction in the rate of churn as it relates to administrative overhead.
    - The provision of premium assistance for Marketplace QHPs is cost-effective, improves access to care, and reduces the impact of churn as individuals transition from eligibility for Medicaid to eligibility for Marketplace advance premium tax credits.
    - Participants will experience fewer gaps in insurance coverage than traditional Medicaid beneficiaries based upon the grounds that they can remain in the same Marketplace QHP if their income increases and they are no longer eligible for the Marketplace Choice Plan.
    - Participants will maintain continuous access to the same QHPs and/or providers at higher rates than beneficiaries under a traditional Medicaid expansion.
- Evaluation:
    - Comparison of administrative costs per capita expended between Marketplace Choice Plan and the Iowa Wellness Plan.
    - Compare churn rates between Marketplace Choice Plan and evidence in literature/other states' experiences with traditional Medicaid expansion.
    - Analysis of Marketplace Choice Plan participant transfers to advanced premium tax credit coverage to measure the percent of Marketplace Choice Plan participants who would have otherwise had to change coverage and/or providers.

Cost

- Hypotheses:

  - The use of the Marketplace for individuals who are at higher incomes will result in savings in both administrative and medical expenditures over the lifetime of the demonstration.
  - The provision of premium assistance for Marketplace QHPs and bringing more Medicaid lives to the Marketplace will increase competition in the private market resulting in lower costs for all Iowans.
  - The incentive program that reduces cost sharing in subsequent years results in increased preventive care and other disease prevention and health promotion activities, which will result in lower health costs and improved health outcomes.
- Evaluation:
  - Comparison of administrative costs per capita expended between Marketplace Choice Plan and traditional Medicaid expansions.

Medicaid Service Benefit Wrap

- Hypothesis:
  - Individuals enrolled in Marketplace QHPs have sufficient access to needed services and do not require Medicaid Benefit Wrap.
- Evaluation:
  - Enrollee satisfaction surveys demonstrate needed services were available and accessible.

Pharmacy

- Hypothesis:
  - QHP Pharmacy benefits are adequate for the enrolled population.
- Evaluation:
  - Enrollee satisfaction surveys indicate sufficient access to needed prescription drugs.

Continuity of Care

- Hypothesis:
  - The use of the Marketplace for individuals who are at higher incomes will result in improved continuity of care for participants.
- Evaluation:
  - Analysis of Marketplace Choice Plan participant transfers to advanced premium tax credit coverage to measure the percent of Marketplace Choice Plan participants who would have otherwise had to change coverage and/or providers.

WAIVER & EXPENDITURE AUTHORITIES

The following includes a list of waiver and expenditure authorities for the Iowa Wellness Plan 1115 waiver request and the Marketplace Choice Plan 1115 waiver request:

1) Amount, Duration, and Scope of Services – Section 1902(a) (10) (B): To allow Iowa to offer a benefit package to participants that differs from the State Plan Services.
2) Rate-setting/Payment methodologies – Section 1902(a) (13) and (a) (30): To allow Iowa to test innovative payment methodologies for combining fee-for-service, care coordination, capitation, and cost and quality indexed bonus payments.
3) Cost-Sharing Requirements – Section 1902(a) (14): To allow the federal regulation of a 5% of income out-of-pocket maximum to be calculated on an annual basis. To allow Iowa to charge a $10 copayment for non-emergency use of the ER.

4) Freedom of Choice – Section 1902(a) (23) (A): To allow the Iowa Wellness Plan to require enrollees to enroll with a PCP. To allow Iowa to make premium assistance for Marketplace QHPs mandatory for Marketplace Choice Plan participants and limit participants' choice of providers to those providers participating in the Marketplace QHPs.
5) Methods of Administration – Transportation – Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53: To the extent necessary, to enable Iowa to not provide non-emergency transportation to and from providers for participants.
6) State-wideness/Uniformity – Section 1902(a)(1): To the extent necessary, to enable Iowa to operate the Iowa Wellness Plan and provide ACOs and/or managed care plans only in certain geographical areas.
7) Retroactive Eligibility – Section 1902(a) (34): To allow Iowa to not offer participants retroactive eligibility.
8) Early Periodic Screening, Diagnoses, and Testing (EPSDT) – Section 1904(a) (4): To exempt Iowa from the requirement to offer EPSDT services to 19 and 20 year olds and allow a standard set of benefits for all participants.
9) Drug Formulary – Section 1902(a) (54): To allow Iowa to limit Marketplace Choice Plan participants to receiving coverage for drugs on the selected Marketplace QHP's drug formulary.

The proposed Iowa Wellness Plan 1115 waiver and Marketplace Choice Plan 1115 waiver documents may be viewed beginning on July 15, 2013, at: http://www.ime.state.ia.us/Initiatives.html.

Written comments may be addressed to Maggie Reilly, Department of Human Services, Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, IA 50315. Comments may also be sent to the attention of: **DHS, Iowa Health and Wellness Plan** at DHSIMEHealthandWellnesPlan@dhs.state.ia.us **through August 15, 2013**. The public, by contacting Maggie Reilly at the above address, may review comments received.